# DOCUMENT RESUME

ED 348 802 EC 301 423

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|---|---|
| AUTHOR | Winget, Pat, Ed.; Kirk, Joyce, Ed. |
| TITLE | California Programs and Services for Students with Serious Emotional Disturbances. |
| INSTITUTION | California State Univ., Sacramento. |
| SPONS AGENCY | California State Dept. of Education. Sacramento. Office of Special Education. |
| PUB DATE | 91 |
| NOTE | 123p.; Prepared by the SED Work Group. |
| AVAILABLE FROM | Resources in Special Education, 650 Howe Ave., Suite 300, Sacramento, CA 95825 ($20). |
| PUB TYPE | Reports - Descriptive (141) -- Reports - Evaluative/Feasibility (142) -- Viewpoints (Opinion/Position Papers, Essays, etc.) (120) |
| EDRS PRICE | MF01 Plus Postage. PC Not Available from EDRS. |
| DESCRIPTORS | Agency Cooperation; *Definitions; Early Intervention; Elementary Secondary Education; Eligibility; *Emotional Disturbances; Handicap Identification; Parent Role; Prevention; *Program Development; Program Evaluation; Resource Allocation; Severe Disabilities; State Programs; Student Evaluation; Student Placement |
| IDENTIFIERS | *California; Early Identification |

ABSTRACT

This monograph presents an overview of the current status of programs for students with serious emotional disturbances in California and makes recommendations for program improvements. An introductory chapter summarizes important themes including screening, prevention, and early intervention; definitions; eligibility issues; assessment; interagency collaboration; existing resources; professional competence; and family needs. The first section then examines the roles of parents stressing the need for educators to see parents as partners. The second section considers aspects of early intervention and assessment including prevention services in the regular program, early awareness and intervention, and the problem of definitions. A major section examines aspects of educational instruction and services. These include: determining appropriate goals and objectives; determining appropriate placement and related services options; organization and delivery of services, educational interventions; and program evaluation. Section 4 considers community services which augment public school service options including mental health program services and other out-of-home services. The fifth section considers personnel development especially the importance of collaborative consultation training. Recommendations stress the shared responsibility of special education, resolving the definition dilemma, allocating sufficient resources, providing a full continuum of service options, and empowering a single case manager. (Contains 53 references.) (DB)

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# CALIFORNIA PROGRAMS AND SERVICES FOR STUDENTS WITH SERIOUS EMOTIONAL DISTURBANCES

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# CALIFORNIA
# PROGRAMS AND SERVICES
# FOR STUDENTS
# WITH
# SERIOUS EMOTIONAL DISTURBANCES

Developed by the SED Work Group
for the Special Education Division
Specialized Programs Branch
California Department of Education

RESOURCES IN SPECIAL EDUCATION
California State University, Sacramento

## CALIFORNIA PROGRAMS AND SERVICES FOR STUDENTS WITH SERIOUS EMOTIONAL DISTURBANCES

Prepared by the SED Work Group as an advisory report to the Special Education Division, California Department of Education. Allan Simmons, Special Education Division Administrator, served as chair of the SED Work Group.

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Photographs courtesy of: Dubnoff Center, Peninsula Children's Center, Oceanside Unified School District, and San Diego Unified School District

This document was edited and prepared by Resources in Special Education (RiSE), a cooperative project of California State University, Sacramento, with the California Department of Education, Special Education Division.

Copies of this publication are available from Resources in Special Education, 650 Howe Avenue, Suite 300, Sacramento, California 95825.

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# PREFACE

My first teaching assignment was with emotionally handicapped kids in Hunter's Point, a suburb of San Francisco. I started in January, and I was the fourth teacher to be assigned to that class. I had not been trained in special ed, so I had to learn very quickly.

I learned a lot over the six months I taught these students. They were 12-year-olds with 3-year-old social skills. That first day there must have been 35 fights in the classroom. They could be the nicest kids and in one second they'd get this flash of anger and stab you with a pencil, throw a bottle at the principal — you just never knew. As soon as the pain of anything hit them — emotional pain, physical pain, stress — they couldn't deal with it. They had to learn slowly how to get control of themselves...to channel that negative energy.

My goal for those students with serious emotional disturbances was to focus on reintegration back into the general education program and society. I spent a lot of time working on developing social skills. We played sports, hiked, camped. I talked to the other teachers at school and negotiated to get about half of my students in their classes for at least an hour so they'd be in a regular situation.

At the end of the year, half of the class did go back into the general education program. That teaching assignment was one of the most difficult of my career, yet one of the more rewarding.

This experience helped me to develop a sense of appreciation for teachers and other professionals who are specially trained to work with challenging students. They are a precious resource to any school and community. School leaders need to welcome these skilled staff and their students as an integral part of the campus, providing ongoing support and linkage to district and community resources.

We, as California educators and concerned, involved community members, must also focus our efforts on prevention and early intervention services. Use the special education teacher, the counselor, the psychologist, and the student's parents as valuable members of the school's student study team. In this way, the student's problems may be able to be addressed early, before they become more severe, and addressed within the general education program. And we in education must not try to do it all. We have excellent resources available from mental health and other state and local agencies. We must team up to meet the complex and challenging needs of these students at the earliest possible moment.

BILL HONIG,
Superintendent of Public Instruction

# FOREWORD

Programs for students with serious emotional disturbances have a long history in California. The Department of Education sponsored research and development in the 1960s that gained national attention and, in 1964, influenced a new California program authorized for "educationally handicapped" students. The emphasis soon shifted, and more attention was given to the area of learning disabilities, a new state master plan for special education, and a federal program for children with disabilities. As a result, current programs for students with serious emotional disturbances vary considerably among school districts throughout the state.

Recent California legislation has created interagency coordination at the state and local levels, renewing interest in standards and eligibility for public school services. The Special Education Division enlisted the assistance of experts to (1) study the current status of programs for students with serious emotional disturbances and (2) to make recommendations for program improvements. A work group was formed to develop this document. *California Programs and Services for Students with Serious Emotional Disturbances* is intended as an overview of existing resources and ongoing concerns regarding the education of students who experience problems in school through behavioral excesses or social inadequacy. It is a starting point from which program innovations and improved services may be promoted in the anticipated changes of the 1990s.

The school's primary focus is education. When considering emotional disturbances in students, educators and other professionals must now also consider other students whose behaviors place them at risk of not learning in an educational environment due to environmental or social factors. The movement to merge special programs in schools into a unified educational system creating a coherent, total school program for every student must also be considered in addressing the special needs of these students. And when schools are utilized as the focal point for all community services, comprehensive programs can be provided.

The work group has developed an overview for providing coordinated school-based services to students with serious emotional disturbances. This document provides information for educators, parents, and mental health professionals on currently available programs and services for students with serious emotional disturbances. The focus is on the changes needed to improve, enhance, and expand these services.

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# ACKNOWLEDGMENTS

The California Department of Education is most appreciative of the persons who volunteered to develop and author this document. Many hours have been spent researching, writing, critiquing, and resolving the content. These people are in touch with current developments and needs in schools and feel strongly that improvements can be achieved. Each participant has been generous with time and talents and has genuinely worked as a team member. Each is listed with affiliation noted at the time this was written.

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The various members of the Advisory Commission on Special Education who participated in meetings of the work group were a valuable resource.

Pat Winget and the staff of Resources in Special Education provided the members with guidance and editorial support in the creation of this document from many individual manuscripts. The work group also thanks Manuel Gonzales and Surender Bhatia for their logistical and secretarial support.

Special thanks are given to the core writing team of Kathleen Berg, Ellen Broms, Donald Doorlag, Brent Duncan, Gil Freitag, and Frank Terstegge.

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# A CASE STUDY

BY HIS MOTHER

***This is an actual case history of a young man with emotional disturbances. John is not his real name.***

In 1977, on a chilly May morning in Boise, Idaho, my son John was delivered with the cord wrapped around his neck, blue, and needing oxygen for almost nine hours. From the beginning, John seemed to be the perfect baby. He slept through the night, nursed well, and would nap, play, etc., oblivious to anything going on around him.

As John grew, it became apparent there was a problem. At nine months, John could take apart and put together simple wooden puzzles and talk in nearly complete sentences. Yet, John couldn't switch from pureed foods to anything with consistency without throwing up. He couldn't crawl, sit well without assistance, nor interact with others unless eye contact was made. Between 22 and 24 months, John regressed in his speech to a nearly nonverbal state. I thought he might be deaf. I received numerous answers from his doctor among them: "He's precocious. He'll learn at the rate he chooses," "John's a smart boy and has figured out the things that concern you," "He has stopped developing in some areas so he can accelerate in others." It was confusing.

At the age of four, John was ready for preschool, and his language skills had returned stronger than ever. I enrolled him in a local Montessori school. Socially, he began to have a difficult time. He didn't listen or follow directions. He would not play with the other kids, but preferred watching or being alone and exploring (usually places he wasn't supposed to be). John became more and more hyperactive, and his inquisitiveness was becoming impulsive and, at times, dangerous. By the time John was 5 1/2 and ready for first grade, it became evident we were going to need some professional help for our son.

Between five and six, John's emotional behavior began to deteriorate. He was having behavior problems in school and was prone to temper tantrums and self destruction. Decision making and concentrating were becoming more difficult for John. We transferred him to a local public school where we were fortunate to have a warm, caring psychologist, principal, and teacher. While doing well academically, John still had problems with following directions, remembering school rules, and anything to do with transitions.

After numerous tests, a child psychiatrist diagnosed John as schizophrenic and admitted him to a children's unit at a psychiatric hospital. After 2 1/2 months of tests, various medications, and behavior modification programs, John came home. He was one month from his eighth birthday and on enough medication to slow down an average adult.

The summer of '85, John had to deal with the separation of his father and myself, a new home, and a new school year. Unable to handle change, John rapidly regressed. Any changes such as a substitute teacher, special assemblies, even going to a new chapter in a book, would cause him to lose his shaky hold on self-control. His behavior problems escalated at school, and he was frequently given in-house suspensions. John started disappearing for hours at a time and became very hostile and paranoid toward other people. He burned down a shed (because "...a big boy told me to") and hid some large carving knives. Feeling John was on the verge of total withdrawal, his doctor admitted John to another psychiatric hospital where he became disoriented and more hostile. I realized I had to help my son. I knew it was time to look past this doctor and all the drugs and find other answers for my son.

I found a special children's center in San Diego. The staff there rediagnosed John and changed his medication. They found numerous emotional problems and a large discrepancy between his intellectual level and his level of understanding. John, with his above-average I.Q., was *emotionally* retarded. John was also found to be extremely impulsive. At his age, he was still poking metal objects into light sockets, touching fire, and playing with knives and razors. John progressed to where he could be placed in a group home. However, he still had major setbacks. One of these setbacks sent John back to a children's unit of a psychiatric hospital where he was then diagnosed as Atypical Psychotic.

I felt like I had come full circle. I couldn't do anything for my son. I could fix his shirt when he ripped it, his hair when he wanted a flat top, his elbow when he skinned it, but I couldn't *fix* John. I couldn't shake the feeling that I had "failed" my son. With the love and support of my new husband, my youngest son, and my family and friends, I slowly climbed out of my depression and once again sought a "special place" for John.

We located a children's center in Arizona that could "keep John safe." Moving John over 200 miles away was one of the hardest decisions I'd ever made. There medications were changed, more tests were administered, and additional answers were found. John was diagnosed as having a Bi-Polar Mood Disorder and an auditory processing deficit. John progressed well enough in this small, structured setting that in one year he was ready to come home.

John was now eleven years old and in the sixth grade. We found a special day class through our local special education consortium and a private day treatment program at a local hospital. John would be on the elementary school campus in the morning and then bussed to the hospital for the mental health component of his day. John seemed to thrive in this small, well-organized class. He even did well enough to earn "Student of the Month" in the fall. In the spring, John was able to play Little League baseball and was chosen for the All-Star team!

A year with numerous highs was followed by a fall of new lows. During late August and early September, John began experiencing the physical and hormonal changes of puberty. A new school, fears about seventh grade, an awareness that he was "different," and a move to the adolescent day treatment program at the hospital all combined to cause another downward slide for John. Puberty seemed to trigger an angrier, more aggressive side of John. Medications were changed and various interventions were tried. In October 1989, John was once again hospitalized. Things went from bad to worse. He set fires in the hospital, punched holes in the walls, and even took up smoking.

In January 1990, we found another residential treatment center where he was rediagnosed as having an Atypical Pervasive Developmental Disorder. This residential treatment center was excellent, but we saw a lot of regression. From February until April, John was admitted and discharged between psychiatric hospitals and the residential treatment center eight times! We finally brought John home, found a full-day treatment program, and tried to stabilize John through our love and support.

On May 31, 1990, John was 13 years old. It was one of the worst days of John's life. He got in a fist fight with the bus driver, spent most of his day in time-out and wouldn't talk at all to us. As he was falling asleep that night, John called me into his room. I hugged him and he started to cry, not little whimpers or loud staged cries, he was crying from somewhere very deep inside. All he could say was, "Mama, I'm not like a teenager." John really thought he would wake up on his thirteenth birthday and he would be "cured." After that, we kept losing John a little bit at a time. For every step forward, there would be three steps back. Something had to be done and it couldn't be just another stay in the hospital.

John is home now but he needs a place to go to school, to learn to make friends, play, and be accepted for the person he is — no matter what the label. Not all children's handicaps are physical and the families of those children with "hidden" disabilities suffer the same pain as those whose children have visible handicaps. Parents of children who are emotionally disturbed share a common problem: Because their child *looks* fine, support from others can be slow to come. Also many parent's own inner fears cause them to give up in the search for help. They begin to worry that the child's problems are due to poor parenting, or they are afraid of the stigma attached to the field of mental health.

For some parents, mourning the loss of unfulfilled dreams and expectations — as well as the difficult task of finding new, equally important dreams — is a lifetime challenge.

This story has no ending — it may never have one. But parents need to know they are not alone in their struggles.

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# INTRODUCTION

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# INTRODUCTION

It has been 30 years since the publication of the last major policy statement regarding programs and services for emotionally disturbed children in California's schools (Bower, 1961). The obstacles and complexities facing parents and professionals as they attempt to serve the needs of children with serious emotional disturbances are still enormous today. This document provides guidance and support for educational and mental health professionals at the local level as they collaborate to develop high quality programs for children whose emotional problems hinder their educational success.

As fiscal resources continue to dwindle, California communities must address the most effective usage of their local resources — the expertise of educational and mental health professionals, the experiential knowledge of parents, the vast resources and research of community colleges and universities, the involvement of local business and industry, and the coordination of all existing programs and services. Professionals need to elicit the support of all of their community to improve the quality of programs and services for children with serious emotional disturbances.

Communities must make a concerted effort to identify emotional problems early in each child's development and provide preventive services such as counseling, peer tutoring, and teacher and parent consultation. Special education services must be made available to young children identified as having a serious emotional disturbance because special education, including mental health services, may be the best means to prevent further deterioration.

Resources within the state and local agencies of education, mental health, social services, health services, developmental services, and alcohol and drug programs should focus on the child within the family unit in providing a comprehensive, coherent, total school program. Parents, both natural and surrogates, need to be active, knowledgeable partners in the program for its effect to be realized and long-range. Educators must be proficient in a variety of alternative instructional strategies in addition to possessing effective collaboration skills.

Although the terminology used to communicate about this population varies depending on the speaker and the audience, this document has adopted the term "serious emotional disturbances" to be consistent with the state and federal definition of the category.

## Background

There is perhaps no area of special education that has produced as much controversy as has the area of serious emotional disturbance. A review of the history of this debate, even within California, is outside the scope of this document. The interested reader is referred to the bibliography for papers by Eli Bower (1982), Jane Knitzer (1990), or Steven Forness and Knitzer (1990), among others, for examples of the numerous problems which have plagued the field.

The needs of children with serious emotional disturbances have been underserved at best and poorly met in general. There is general consensus that children with emotional disturbances are underidentified to a tremendous extent. Based on figures reported to Congress for the Twelfth Annual Report on the Education of the Handicapped Act (1990), children who are identified with serious emotional disturbances (SED) make up approximately 0.256 percent of the school-aged population in California, which is at least 10 times less than one would expect, even using the most conservative prevalence figures from the professional literature. California is currently among the lowest three or four states in the country in the proportion of children served as SED. Currently, fewer than 5 percent of students with serious emotional disturbances are mainstreamed to any extent whatsoever. More than one in three students with serious emotional disturbances attends a nonpublic school, suggesting that students currently being served require a more intensive program than what is available in their local school.

There are many reasons for the current state of affairs. One important reason is that any definition of serious emotional disturbance is ultimately a subjective matter (Kauffman, 1989). Many advocates view the federal and California laws as serious obstacles to providing appropriate services (Duncan, 1990; Forness and Knitzer, 1990). By contrast, a 1985 study adopted by the U.S. Department of Education (SRA Technologies, Inc., 1985) found that there would be few demonstrable benefits from making any SED definitional changes (U.S. Department of Education, 1985). Kauffman (1989) has suggested returning to Bower's original definition, which he views as "admirably suited for use in educational settings."

The fact that there is little professional agreement or acceptance regarding the educational definition of serious emotional disturbance has made collaboration between the educational and mental health systems very difficult.

The challenge inherent in developing programs, which by definition must involve multiple agencies and disciplines, is extraordinary. The collaboration and cooperation, which are essential if coordinated services are to be developed, is

exceedingly difficult, even given ideal circumstances. Lack of adequate funding for preventive as well as comprehensive services is another serious problem. Additionally, the tremendous shortage of trained teachers and support personnel and the lack of appropriate professional standards for training SED teachers make it extremely difficult in many parts of the state to assemble a team of practitioners with even minimally acceptable training. For example, current law permits the SED teacher to possess a severely handicapped specialist teaching authorization despite a basic mismatch between the requirements for the credential and the educational needs of students with serious emotional disturbances. It is incorrect to assume that a school psychologist has had specific training in the area of SED diagnosis and intervention or that a school counselor has had supervised clinical experience with this population.

## Current State of Affairs

The problems experienced in California are reflective of those faced by parents and professionals throughout the United States. With the changing California demographics and the serious shortage of funds the problem is particularly acute, and families experience extreme stress while attempting to find services for genuinely troubled youngsters. Despite this rather bleak backdrop, there are significant reasons to be encouraged. There is a sincere belief among those in educational services that there are solutions to many of the problems. This is a hopeful document, designed to be of immediate assistance to parents, superintendents, program managers, and service providers. The following summarizes several important themes in this document.

### Screening, Prevention, Early Intervention

Services for children with emotional disturbances must be conceptualized within the overall framework of services to *all* children. Providing appropriate services for children with serious emotional disturbances is a shared responsibility among parents, all teachers, student support and administrative personnel, and special education staff. Prevention activities, early recognition of students at risk of school failure, screening, and intervention within the regular school environment are essential to the success of model SED programs. In this context, the student study team has a vital role to perform, not to delay the provision of specialized services, but as a genuine attempt to utilize the resources of the school to serve all children in the least restrictive environment. Development of effective SED programs is firmly embedded within the general reform effort throughout the nation involving youth at risk of school failure.

> ***It is not believed that special education is necessarily the treatment of choice for all children with social and emotional problems; however, all children are entitled to an educational environment appropriate to their needs.***

## Definitions

It is widely believed that the definition of serious emotional disturbances that is contained in Public Law 94-142 is seriously flawed. This means that eligibility decisions among children who are traditionally labeled "seriously emotionally disturbed," "behavior disordered," "socially maladjusted," and "conduct disordered" will continue to be difficult, at best.

Currently, there is a nationwide effort to change the federal definition to be more inclusive of all these disorders (Forness and Knitzer, 1990). The definition of SED contained in the Individuals with Disabilities Education Act (IDEA) has been defined in many different ways by several states and remains an area of diverse opinion among professionals regarding the large group of children who display varying degrees of dysfunctional behavior.

It is important to have a differential diagnosis which clearly assists the IEP team in writing appropriate goals and objectives for these students in regular or special education programs. Because of the complexity of this disability and the lack of highly objective measures, definitions should not be a basis upon which to deny services, but individual diagnostics should lead to the most appropriate manner in which to educate these students. It is not believed that special education is necessarily the treatment of choice for all children with social and emotional problems; however, all children are entitled to an educational environment appropriate to their needs.

## Eligibility Issues

Eligibility for SED services and placement in a special environment are completely separate steps. Just because a student is found eligible for SED services does not mean that he or she is immediately placed in a special day class or residential treatment center. The entire range of services, from the general education classroom with support services to placement in a hospital setting, must be considered. The concept of least restrictive environment is perhaps more critical for students with serious emotional disturbances than for any other category of special education. The burden clearly rests with the individualized education program (IEP) team to document why a more restrictive environment is necessarily the most appropriate placement and why the needed services can not be provided in a less specialized setting.

### Assessment

Assessments that are conducted to determine SED eligibility must provide information that will guide interventions, whether the child is eligible for special education or not. Far too much emphasis has been placed on conducting assessments designed solely to address questions regarding eligibility, which are often of little use for the purpose of program or instructional development.

***The concept of least restrictive environment is perhaps more critical for students with serious emotional disturbances than for any other category of special education.***

### Interagency Collaboration

Perhaps the single most important factor in the development of quality programs for children with serious emotional disturbances is the element of interagency trust, cooperation, and collaboration. Children with serious emotional disturbances and their families frequently come into contact with many different agencies representing many disciplines. Possibilities for conflict between agencies exist at every step in the process. Differing assessment and eligibility models, different treatment philosophies, concerns about confidentiality, and entrenched bureaucratic rule systems are just a few of the areas of potential conflict. The need to collaborate across traditional boundaries among agencies and to develop truly integrated services is essential. In most settings, this means that participants will have to change some established methods of practice in significant ways.

One of the most important recent developments since the implementation of Government Code Chapter 26.5 (AB 3632), Interagency Responsibilities for Providing Services to Handicapped Children, is the cooperative effort of school districts and local mental health agencies to jointly serve students with serious emotional disturbances on public and nonpublic school campuses. Throughout California, partnerships are being developed in which mental health services, both outpatient and day treatment, are provided on school sites. This practice minimizes the disruption of the educational program of the students with serious emotional disturbances and maximizes the potential for genuine collaboration and integration among mental health and educational professionals. The sharing of resources, the daily interaction of staff, and the mutual support and understanding that can develop is a tremendous asset for students with serious emotional disturbances and their families. It also has been shown to be efficient and cost effective, when compared with providing non-integrated services. This practice is strongly encouraged as it underscores the efficacy of interagency cooperation in a determined effort to share responsibility for impacting the lives of children and adolescents with the most serious emotional disturbances in their community.

Another means for ensuring interagency integration of services for each student is for the individualized education program team to designate a "case manager" to facilitate and monitor communication and coordination among the various agencies involved in the evaluation or treatment of that child. An additional possibility is to have cooperative training opportunities for service providers involved with children with serious emotional disturbances. Cooperative exchanges must extend to all levels of the system, including parents, teachers, and therapists, as well as program managers, psychologists, and other administrative and ancillary personnel. Interagency councils at the county level are extremely important, but collaboration at the level of service providers (teachers and treatment personnel) is equally critical.

## Existing Resources

A tremendous number of excellent resources exist to assist schools and mental health systems to develop high quality education and treatment programs for students with serious emotional disturbances. An overview is provided of current best practices in the areas of academic instruction, social skills development, behavior management, counseling, and the design of therapeutic environments for children with serious emotional disturbances. It would not be possible in a document of this length to outline, or even to mention all treatment options, nor should it be implied that there exists a single set of interventions with demonstrated efficacy for all students with a specific problem. However, all service providers are strongly encouraged to utilize current research and identified standards of quality and effectiveness in their development of programs and not simply rely on "whatever's available" or "whatever works" to design classroom and treatment plans.

## Professional Competence

School districts and mental health agencies must assess the prior training and areas of professional competence for staff who are assigned to SED programs. It is not reasonable to assume that teachers, administrators, school psychologists, or even therapists have received adequate training in the area of assessment and treatment of serious emotional disturbance. Inservice training must be provided in areas of weakness, drawing upon expertise at local colleges and universities, county offices of education, local mental health agencies, and from private practitioners in a collaborative effort. Transdisciplinary training programs involved in the preservice education of teachers and support personnel must be encouraged to develop comprehensive training for future practitioners with children with serious emotional disturbances.

## Family Needs

Finally, services for children with serious emotional disturbances should reflect the needs of both the child and family. Parents must be treated as partners and serve as full participants in all aspects of planning and delivering services and be provided the necessary knowledge and skills to do so.

As stated earlier, this is a hopeful document. It represents a significant effort on the part of the California Department of Education to assist school districts, together with mental health and social service providers, to develop outstanding programs for students with serious emotional disturbances and their families. There are wonderful programs scattered in all corners of California, and others are encouraged to do "whatever it takes" to ensure that students with serious emotional disturbances are provided with an appropriate education in all districts in this state.

## SECTION 1

# ROLES OF PARENTS

Parents as Partners .......... 13

21

# ROLES OF PARENTS

## Parents as Partners

Over the past decade, the concept of parent professional collaboration has gained increased credibility and support among parents and professionals serving families. Acceptance of this philosophy of shared responsibility in the development and implementation of services for children is reflected in a growing body of professional literature and in the activities of parent self-help and advocacy groups. In addition, specific mandates and guidelines for parent involvement have been established in the field of special education through the passage in 1975 of P.L. 94-142, the Education of the Handicapped Act (now Public Law 101-476 called the Individuals with Disabilities Education Act). Within the field of mental health services for children, parent-professional collaboration has been promoted through the Child and Adolescent Services System Program (CASSP) of the National Institute of Mental Health. This national initiative to support state efforts in developing comprehensive and innovative services for children with serious emotional disturbances and their families encourages family participation at all levels of program development, implementation, and evaluation.

For the parents of a child with an emotional disturbance, the absence of a coordinated and comprehensive services system has intensified the stress resulting from the struggle to find services and to pay for treatment. Parents are forced to cope on a day to day basis with the difficult behaviors and needs of their child while trying to maintain some sense of normalcy in their family and community. Parents' efforts to help their child and family are often further burdened by the perception of some professionals and society at large that the parents themselves have caused, or are in some way culpable for, their child's disability. Too often, the relationship between parents and the professionals serving the family is fraught with misunderstanding, suspicion, doubt, and conflict. Certain theoretical perspectives help to create and maintain the bias towards viewing parents as pathogenic, thereby restricting parents to a role of service recipient. These perspectives will need to give way to less prejudicial, more compassionate ones in order for true collaboration of parents and professionals to occur.

Such views of family pathology have not gone unnoticed or unfelt by parents. The stigma and guilt of having a child with serious emotional disturbances can have a profound impact that is paralyzing, particularly when placed within the context of a daily struggle to cope with the troublesome and often unpredictable behaviors of a child with serious emotional disturbances. Even more devastating, perhaps, is the distinct possibility that the parent may feel such stigma not only from interactions with professionals, but from other family members, relatives, and friends as well (Friesen, 1989b).

In response to these problems, major initiatives at the federal, state, and local levels have been undertaken in recent years to develop comprehensive systems of service and care that are responsive to the needs of families whose children have serious emotional disturbances. A guiding principle for the development of these services is that services should reflect the needs of the child and family, and that families of children with serious emotional disturbances must be full participants in all aspects of planning and service delivery (Friesen, Griesback, Jacobs, Katz-Leavy, and Olson, 1988; Stroul and Friedman, 1986).

In concert with these formal systems efforts, the 1980s have witnessed the rapid development of organized parent advocacy efforts. Within California, federally funded parent training and information centers are effectively working with parents of children with disabilities (Team of Advocates for Special Kids, MATRIX, Parents Helping Parents, and Disability Rights and Education Defense Fund). The emergence of parent support and self-help groups specific to parents of children with emotional disturbances has provided new arenas for parents to obtain needed emotional support, information on their child's condition, and skills and opportunities to advocate for necessary services. As these groups develop and grow in numbers, they are having a profound impact on the traditional forms of interaction between parents and professionals.

This perspective of *parents as partners* emphasizes that parents hold the primary and continuing responsibility for the caretaking, education, development, and treatment of their children. Parents of children with serious emotional disturbances have these ongoing caretaking responsibilities throughout the child's life, often with only episodic professional assistance. Effective help-giving for families must prioritize interventions that build on and support family strengths and integrity to meet needs and promote the family's ability to acquire and sustain resources as well as to become effective at problem solving. This collaborative framework, in which professionals are viewed as resources to the family, "empha-

## Parent Facilitator Program

*The San Diego City Unified School District's Special Education Parent Facilitator Program trains and hires parents to serve as resources to educate other parents. A cadre of parents who understand both the issues of parenting a child with disabilities and the district's special education program are employed as parent facilitators for the district. An 80-hour training course provides information on district organization, communication skills, laws and current legislation, handicapping conditions, the IEP process, and personal time management skills.*

*As the district serves a large population of multicultural, lower-income and single parents, there is often a need to provide accessible communication and information about community agencies. The facilitator program maintains a library and information center of community resources and produces written materials to share specific information.*

sizes that family care-givers in their own right are capable diagnosticians (at least in terms of needs and services) and can carry major responsibilities for much of the treatment/rehabilitation process" (Moroney, 1986, p. 124).

Given the complex nature of serious emotional disturbances in children and the lack of a cohesive and coordinated system to deliver services, it is not unusual for a family to be receiving services from a number of agencies and private providers simultaneously. In the absence of a coherent, coordinated approach, these services may be a source of added stress for the family.

Families that do not seek assistance until they have exhausted their own resources are often desperate and under acute stress. They need immediate relief for their child and family. In response to such crises, professionals need to fully communicate with the family in order to receive a more complete understanding

## Effective Parent-Professional Collaboration For Professionals:

- Have I put myself in the parent's place and mentally reversed roles to consider how I would feel as the parent of a child with an emotional disability?
- Do I see the child/adolescent in more than one dimension, looking beyond the diagnosis or disability?
- Am I able to keep in mind that the child/adolescent is a person whom the parent loves?
- Do I really believe that parents are equal to me as a professional and, in fact, are experts on their child?
- Do I consistently value the comments and insights of parents and make use of their reservoir of knowledge about the child's total needs and activities?
- Do I judge the child/adolescent in terms of his or her progress and communicate hope to the parents by doing so?
- Do I make a consistent effort to consider the child as part of a family, consulting parents about the important people in the child's life and how their attitudes and reactions affect the child?
- Do I distinguish between fact and opinion when I discuss a child's problem and potential with a parent?
- Do I make every effort to steer parents toward solutions and resources, providing both written and oral evaluations and explanations as well as brochures about potential services, other supportive arrangements, and financial aid?
- Do I see as my goal for interactions with parents the mutual understanding of a problem so that we can take action as a team to alleviate the problem?
- Do I actively involve the parents of each child in the establishment of a plan of action or treatment and continually review, evaluate, and revise the plan with the parents?
- Do I make appointments and provide services at times and in places which are convenient for the family?
- Do I obtain and share information from other appropriate professionals to ensure that services are not duplicated and that families do not expend unnecessary energy searching for providers and services?

*Taken from "Working Together: A Training Handbook for Parent-Professional Collaboration" (1987), by Richard Vosler-Hunter and Kaye Exo, Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute, Portland State University.*

of the family's situation and needs. Likewise, clear communication and an understanding of the demands and stress experienced by the family will lead the professional to understand the motives of parental behavior. For example, as parents traverse the complicated mental health system, they may approach many service providers while seeking assistance. This may be viewed as negative *shopping behavior* when, in fact, the behavior is due to the inability of parents to find needed services (Olson, et al., 1983).

In spite of all the potential barriers, it is reasonable to believe that collaboration between parents and professionals can exist. Given the successful efforts of parents and professionals in other fields of disability, the growing commitment of federal and state policy-makers to the philosophy of collaboration, and the mounting demands of parents and parent advocacy organizations for their involvement, the outlook is extremely positive and the goal achievable. Parents and professionals must understand (1) what the elements of collaboration are, (2) what a collaborative relationship looks like, and (3) how to make the relationship work (Vosler-Hunter, 1989).

## Effective Parent-Professional Collaboration For Parents:

- Do I believe that I am an equal partner with professionals, accepting my share of the responsibility for solving problems and making plans on behalf of my child?
- Am I able to see the professional as a person who is working with me for the well-being of my child?
- Do I see as my goal for interactions with professionals the mutual understanding of a problem so that we can take action as a team to alleviate the problem?
- Do I maintain a file of important documents and correspondence so that I have a complete history of services provided to my child and family?
- Do I clearly express my own needs and the needs of my family to professionals in an assertive manner?
- Do I accept the fact that a professional often has responsibility for service coordination and communication with many families, including my own?
- Do I communicate quickly with professionals who are serving the needs of my child when there are significant changes or when notable situations occur?
- Do I communicate with other parents, thereby reducing my isolation and theirs, and sharing my expertise?
- Do I encourage the professionals involved with my child to communicate with each other and keep me informed as well?
- Do I maintain realistic expectations of professionals, myself and my child, knowing that complete and definitive answers are unlikely when complex emotional and physical conditions of children are concerned?

*Taken from "Working Together: A Training Handbook for Parent-Professional Collaboration" (1987), by Richard Vosler-Hunter and Kaye Exo, Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute, Portland State University.*

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By virtue of their status, parents are indeed experts on their child and family. No amount of interviewing or analysis can ever yield for the professional the unique understanding of the family that the parent can offer. Parents have a vast repertoire of skills and wisdom concerning what *works* and what does not work with their child, how services help or hinder the family, and what needs the family has or doesn't have. Professional efforts are likely to be limited to the extent they exclude the wisdom and involvement of the parents and family members. Using specialized skills obtained through training and experience, professionals offer parents opportunities to obtain new knowledge about their child's condition and behavior, adapt or change methods and behaviors to be more successful, and try new ways to assist family functioning. Success is more often achieved when the professional team adapts the services to meet the needs of the child and family. Successful collaboration occurs only when parents and professionals blend these skills and knowledge, recognizing the unique contributions each brings to the relationship (Vosler-Hunter, 1989).

### Effective Parent-Professional Collaboration For Service Providers:

- Are there program goals that embody a commitment to parents as equals with professionals in a team approach to meeting the needs of children?
- Do parents participating in collaborative committees represent a variety of racial, cultural, economic, educational, and geographic backgrounds?
- Do parents participating in collaborative committees include those whose children have been newly diagnosed, those who are experienced in identifying services, and those representing parent organizations and coalitions?
- Are parents included along with professionals for inservice programs designed to build collaborative skills on an ongoing basis?
- Do both formal and informal procedures exist to ensure effective parent-professional collaboration at all levels of the organization?
- Are there mechanisms for receiving information from parents and parent groups and for disseminating information to them?

*Adapted from a Checklist for Effective Parent/Professional Collaboration, one of several checklists created by Terri L. Shelton, Elizabeth S. Jeppson, and Beverley Johnson in "Family Centered Care for Children with Special Health Care Needs." (1987). Washington, D.C.: Association for the Care of Children's Health.*

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## SECTION 2

# EARLY INTERVENTION AND ASSESSMENT

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# EARLY INTERVENTION AND ASSESSMENT

## Prevention Services in the Regular Program: The Early Years

"A school system that attempts to educate all of its children and youth cannot afford to deny or minimize the problems presented by emotionally handicapped children....Unless California schools find methods of providing programs appropriate to the needs of the emotionally handicapped, each community will be burdened with the problems generated by groups of young people who are poorly prepared academically and vocationally and who have strong feelings of personal inadequacy and of hostility toward the school and the community. It was pointed out and documented that these children will, if left alone, one day form the bulk of adults in prisons, mental hospitals, alcoholic wards, and clinics as a result of their inability to function educationally, socially, economically, and emotionally....No state that expends vast sums of money for treatment, hospitals, clinics, and camps can afford to overlook ways in which this burden can, to some extent, be reduced or prevented. Public schools, in adhering to compulsory school attendance laws, must develop the "know-how" and resources necessary to provide appropriate learning experiences for all students, including those with emotional and social problems."

Francis W. Doyle
Deputy Superintendent of Public Instruction
Chief of the Division of Special Schools and Services
California Department of Education
March 1961

***Recent research has suggested that by the end of high school, approximately 30 percent of today's elementary school population may be characterized by one or more of the following: school dropout, runaway, seriously delinquent, antisocial, clinically depressed, pregnant, heavy drinker, or substance abuser (Lambert, 1988).***

This statement, published in the preface to the last document prepared by the California Department of Education regarding programs for students with serious emotional disturbances, is as appropriate today as it was 30 years ago. Recent research has suggested that by the end of high school, approximately 30 percent of today's elementary school population may be characterized by one or more of the following: school dropout, runaway, seriously delinquent, antisocial, clinically depressed, pregnant, heavy drinker, or substance abuser (Lambert, 1988). The individual tragedies and the burden on society that unsuccessful, seriously disturbed, and dysfunctional youth create is enormous. Social, emotional, and behavior problems that are identifiable during the early school years are critical antecedents to most of these adolescent outcomes. Early recognition and intervention is essential with children whose behavioral patterns indicate the risk of developing more serious problems if educational and vocational options are to be preserved for all youth. When these children do not receive needed services, they contribute to a dysfunctional school climate making it difficult for all students to succeed.

There are many serious obstacles facing school and mental health professionals as they attempt to identify and treat children with serious emotional disturbances in California. Many professionals have fears regarding the premature or inappropriate labeling of vulnerable children as emotionally disturbed and the stigma that such a label often carries. In many districts, well-meaning practitioners are poorly equipped and inadequately trained to assess the culturally diverse and rapidly changing student population facing them. The labeling of culturally different children as deviant or disturbed is obviously inappropriate and unacceptable. The removal of disruptive students from the general education classroom without first providing a program of prevention and early intervention is equally improper. Special and general education personnel need encouragement to develop collaborative and creative means of identifying potential problems and intervening with these children before problems become serious enough to warrant removal from the regular class.

Within the school system, site level managers can develop and empower student study teams to identify, coordinate, and deliver services to children and teachers within the context of the general education program. Incentives need to be provided to encourage teachers and support staff to develop alternatives that accommodate the unique individual characteristics of these children and also to assist troubled children to adapt to the demands of school.

There is currently a growing consensus among educational and mental health professionals that federal, state, and local programs and initiatives for children need to be integrated into a single network of care. This network must be comprehensive and include prevention and early identification components, as well as diagnosis, treatment and, rehabilitation services. The provision of these services will involve the educational, mental health, medical, child welfare, and juvenile justice systems. The public school system is the one agency with the mandate to serve the educational needs of *all* children, including those who are at risk as a result of emotional or behavioral difficulties. In many communities, the school is a natural focal point for needed services for all children. Available resources within and outside the school — such as primary prevention programs, out-patient counseling, case management, family counseling — can be coordinated to assist in the development of a comprehensive system of services. In a coordinated system, all partners are called upon to make significant changes, and legislation mandates a broader spectrum of services for *all* children with serious emotional disturbances — not just those identified eligible for special education programs and services.

To be effective, efforts aimed at reducing the risk for serious emotional problems need to involve all children. This does not mean that all children need treatment or other direct services, but does imply that systematic identification procedures should be in place from the primary grades through high school to find those children who are at risk of developing more serious problems. Children who are not yet seriously emotionally disturbed but who have significant and identifiable social or emotional problems that are affecting school performance can be identified and interventions developed. The appropriate services for these children are commonly referred to as prevention or as early intervention.

There is a significant body of research which indicates that many emotionally delayed and mildly troubled youngsters profit and thrive in the general classroom environment when appropriate interventions and support systems are developed and available to the classroom teacher. Making services for emotionally and behaviorally troubled children available to everyone as part of the normal educational process reduces legitimate concerns about labeling and stigmatizing young children with mild to moderate problems. In some districts, the provision of services in the general education classroom will require a more effective use of available resources, such as the utilization of school psychological, specialized resources (e.g., behavior specialist) and counseling personnel in the design and implementation of classroom consultation and counseling programs which promote processes that support and enhance students' emotional well-being. It needs to involve the development of local resources to deal with a wide range of individual, familial, and cultural differences among children. It will require the use of classroom or schoolwide screening procedures for identifying risk characteristics. Finally, the assessments which are conducted must be designed to assist in the development of social and instructional objectives and interventions and not be limited to addressing questions regarding diagnosis or eligibility.

The design and dissemination of responsive, school-based service delivery models are absolutely crucial. Principals are encouraged to conduct needs assessments, utilize student study teams, create inservice training opportunities for staff, and consider all available local resources to develop a school climate where the education of all children — including those with emotional and behavioral problems — is genuinely seen as a common and shared concern.

***The delivery system for serving students with serious emotional disturbances currently prevalent in California schools requires that the child's emotional status be in a state of crisis or long-term deterioration and that their educational performance be significantly impaired as well.***

A preventive approach to the treatment of students with serious emotional disturbances is consistent with California's other educational reform efforts currently underway. Two related questions are critically important in the design of preventive programs. First, how (and how early) can students be recognized who are at risk of developing more serious problems? Second, what are the most promising practices for intervening with children who have been identified as having social or emotional difficulties?

## Early Awareness and Intervention

The delivery system for serving students with serious emotional disturbances currently prevalent in California schools requires that the child's emotional status be in a state of crisis or long-term deterioration and that their educational performance be significantly impaired as well. This is a result of California's use of the federal definition of serious emotional disturbance that is contained in P. L. 94-142 which focuses upon students whose problems have become so severe that they now require extensive services over a long period of time, usually in a highly restrictive setting. Students with serious emotional problems are obviously entitled to appropriate and expeditious educational and related services. However, early intervention services need to be provided equally to all students at risk of becoming seriously emotionally disturbed.

### Recognition

Early intervention can be conceptualized in two ways. First, early intervention occurs with students in their early years of schooling. The Primary Intervention Program serving students in kindergarten through third grade provides an excellent example. Second, early intervention should also occur with students anywhere in the preschool-to-12th grade continuum at any time they become at risk of being seriously emotionally disturbed. This implies that school staff must be sensitive to changes in student behavior and recognize those changes which may be indicative of developing problems. Early intervention in this case would be intervention prior to the onset of more serious or debilitating emotional problems; i.e., before the existing healthy resources of the child and family are depleted. The rationale for providing early intervention is the obvious benefit of providing corrective treatment before the symptoms become so serious that costly, scarce, long-term, and restrictive treatment resources must be utilized.

## Screening

The success of early intervention will depend on the ability of each responsible local education agency to reliably screen students for risk characteristics indicative of emotional disturbance. Each district should have in place a method for conducting systematic screenings of the general education population to identify those children at risk of the development of emotional or behavioral problems. The goal is to identify children with significant emotional and/or behavioral problems which are interfering with learning, but whose problems can be dealt with in the general educational environment. This screening process begins in preschool and continues through 12th grade. Screening of all students occurs annually within the first three months of school at every grade level. In addition, late arrivals are screened within 60 days after they have entered school.

Several reliable instruments are available to conduct the necessary screening. Many instruments have been designed for screening entire classrooms of students using teacher judgment and observation, with minimal training and

### Detection and Prevention Program

*The Primary Intervention Program (PIP) has been supported by the California Department of Mental Health since 1982. The Primary Intervention Program (PIP) for kindergarten-to-3rd grade children is a school-based mental health intervention program for early detection and prevention of school adjustment problems. These programs have been implemented successfully in many of California's 58 counties.*

*The Primary Intervention Program funds three-year demonstration projects which provide screening and non-structured play sessions. Through the use of screening procedures, PIP identifies primary grade children with early school adjustment problems. Once identified, they receive services from carefully selected, trained paraprofessional childrens' aides who work under close school-based professional supervision. These aides receive additional training and consultation from the county mental health program. Each child is seen for a weekly 30-to 40-minute play session in which the aides, through play techniques and reflective listening, help the child overcome problems such as aggression, shyness, or inattentiveness that interfere with the child's learning at school. The goal is to help children get a good start in school by fostering a healthy self-concept, positive social skills, and skills in task completion.*

*The key to the identification of students who develop serious problems subsequent to screening is ongoing sensitivity to changes in student behavior on the part of teachers and other school personnel. Staff development can develop an awareness of the subtle and overt signs of distress.*

specialist time involved. An effective screening program will collect information in a relatively nonintrusive and efficient manner that is directly related to the development of interventions and programs for individual children, as well as entire classes or schools. It is in this way that screening is genuinely preventive.

Districts rely on their professional psychological staff to assist in evaluating the validity and efficacy of particular instruments. As in all areas of assessment, instruments must have demonstrated validity for the purpose they are being used. All professional standards contained in the *Standards for Educational and Psychological Testing* (American Psychological Association, 1985) are to be met prior to beginning a screening program.

In designing or developing other screening instruments, the cultural, ethnic, socioeconomic, and linguistic diversity of the student population needs to be carefully considered. All school personnel should be trained, informed, and sensitive to differences in children's behavior which may be attributable to cultural or experiential differences. If available instruments do not have valid norms for the district's student population, serious consideration should be given to the development of local norms for screening instruments.

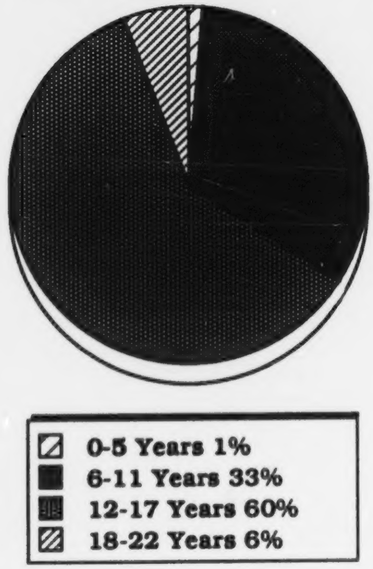
The use of screening and early identification strategies for every student provides the information necessary for early intervention. The key to the identification of students who develop serious problems subsequent to screening is ongoing sensitivity to changes in student behavior on the part of teachers and other school personnel. Staff development can develop an awareness of the subtle and overt signs of distress. This staff development effort needs to include teachers, psychologists, counselors, administrators, nurses, as well as office and all ancillary staff. Once awareness is developed, a reporting protocol needs to be in place so that appropriate staff will be utilized in the further assessment of identified students. Corrective measures or interventions can then be taken to provide appropriate services.

## Intervention

Administrators and support staff must possess the expertise and resources necessary to assist teachers to deal effectively with students who are having social, emotional, behavioral, or academic difficulties. Significant resources need to be focused on this task. A systematic staff development program can identify strengths and weaknesses of school personnel in this area. Following a needs assessment, existing school and community resources can be mobilized to assist both teachers and support personnel to work more effectively with troubled students.

## Ages of SED Students Enrolled Dec. 1990

Enrollment figures show the majority of students identified as seriously emotionally disturbed are 12- to 17-years-old. This may indicate the need for more effective screening and early identification efforts.



*(Data taken from Dec. 1, 1990 Pupil Count, California Department of Education, Special Education Division)*

Interventions should focus on the parents and families, as well as children and classroom teachers. Children's problems often result from unique interactions between internal conflicts and environmental stresses (Sameroff, 1987; Saxe, Cross, & Silverman, 1988). Interventions for emotionally vulnerable children must reflect this complexity, and systems need to be in place which are capable of responding with a diverse set of interventions which impact variables in the school, the family, and the community, as well as those within the child. What follows is a brief summary of those resources and "best practices" coordinated through the student study team process operating in schools in California in order to address the social and emotional needs and problems of students.

### Student Study Teams

The most critical component needed to implement a preventive approach is a fully functioning, empowered, and well-integrated student study team. The team can be composed of individuals from the district, special education local plan area (SELPA), and the community. Teachers, support staff, and administrators with knowledge of curriculum, instructional strategies, classroom behavior management, and other strategies are important team members. The team must have the authority to implement interventions designed to assist students at risk, their teachers, and parents.

The following are examples of ways in which student study teams should be able to assist teachers to intervene with troubled or troubling children.

1. **A clearly understood plan** for identifying social, emotional, and behavior problems and developing appropriate interventions. Skilled and knowledgeable assistance is needed in areas such as:
    - The observation, monitoring and recording of student behavior
    - Basic understanding of behavioral principles (antecedents and consequences) and the communicative function of behavior
    - Basic understanding of child development, particularly as they relate to social and curricular demands
    - Crisis intervention strategies
    - Social and problem-solving skills training
    - Individual and group counseling strategies

2. **A vehicle that establishes clear lines of communication** with student's parents or guardians to ensure a vital home/school working relationship.

3. **A clearly articulated, and culturally sensitive, behavior management system.** There should be an overall policy statement that includes:
    - Clear and appropriate behavioral expectations

- Plans for the development of appropriate cognitive, social, or interpersonal skills on the part of troubled students
- Staff training and development in areas such as nonconfrontive and nonaversive behavior management and other specialized intervention techniques, systems of providing positive reinforcement, appreciation of cultural differences, as well as physiological and neurological factors that affect behavior
- Clearly defined plans for dealing with identified social, emotional, and behavioral problems, specific and logical consequences for misbehavior (such as loss of privileges, contingency contracts, token economies, or similar management systems)

4. **Appropriate behavior management strategies and support for specialized intervention** in the general education program. This may include:
    - Counseling and support by the school principal, counselor, and/or psychologist
    - On-campus study halls
    - Teacher support teams for planning immediate assistance with disruptive students
    - Other modifications of the school day
    - Use of the district school attendance review board (SARB)

5. **Guidelines for the provision and delivery within the school of counseling services** for emotionally troubled or vulnerable students. These services may include individual, family, group, whole class, or crisis counseling depending on the situation.

6. **Consider using the case management process for the monitoring of students.** This implies that a particular team member coordinates all necessary intervention and service delivery for these students on a case by case basis.

7. **Clear linkages and lines of communication with community and agency sources of support** for students and families. Parents should be informed of available resources such as counseling, tutoring, and support groups. The school support staff can provide case management contacts in the community to assist families in finding support including parent training.

Preventive efforts and classroom modifications may not be sufficient to allow many youngsters with serious emotional disturbances to profit from the general educational program. An emphasis on prevention is not meant to delay or deny special education services to genuinely handicapped students. At some point, school personnel may want to consider more intensive treatment options in order to provide an appropriate educational program for a particular student. It is at this point that eligibility for special education becomes a crucial issue, and a clear understanding of the educational significance of serious emotional disturbance is necessary.

The Individuals with Disabilities Education Act (IDEA) mandates and defines services for students with disabilities found eligible for special education. Less well understood, is the school's responsibility for students with disabilities under the Americans with Disabilities Act (ADA, P.L. 101-336) and Section 504 of the Rehabilitation Act of 1973. For example, even though an IEP team finds a student with an emotional or behavioral disability ineligible for special education under IDEA, the school may still be required by ADA and Section 504 to provide the student with appropriate services in order to ensure an opportunity for an education. The mandates for services under ADA and Section 504 need to be considered when determining eligibility under the IEP. This applies to the child's rights to be identified and assessed for a disability.

## The Problem of Definitions

There are many issues surrounding the various concepts of behavior and the school programs effective with these students. The significance of these issues is not etiology or eligibility, but the crucial programmatic decisions that need to be made in both designing programs and the placing of students in appropriate instructional settings. Regardless of the label or behavior, every student should have the benefit of those interventions that can maximize the opportunity for a positive learning experience and opportunity for social development.

Practices dating back to the Educationally Handicapped Program and perceived changes under the California Master Plan for Special Education and P.L. 94-142 have left wide disparities in the use of definitions among professionals and agencies (despite reference to the federal definition). The degree to which professionals choose to think positively of prevention and giving assistance versus choosing to think of punishment for the student's "deliberate defiance" affects both assessment and intervention practices. Lack of resources in general education reduces regular classroom services, and administrative fear of limits to expulsion lessens chances for a pupil not earlier assessed to be found eligible as an individual with exceptional needs. Some educators prefer "learning disabled" or "other health impaired" labels to the more accurate label of "serious emotional disturbance." In some cases, services are provided on the basis of the label, rather than on the assessed need. Educators need to realize that a student, in differing situations

***Behavior disorders are found along with other disabilities and require careful assessment to determine the relationship of the behaviors to a learning disability or other condition eligible for special education programs and services, such as serious emotional disturbance or autism.***

or time, could qualify for more than one categorical classification and frequently may have behavior as a component in a dual diagnosis.

More clarity or amended laws and regulations are needed that define the specifications under which education provides services for this population. Some currently accepted characteristics of students with behavior or emotional disturbances are listed below. They are not intended to be guidelines that differentiate among the various diagnoses of behavior.

## Behavior Disorder

This term is used both to refer to all types of disability from behavior and to describe a particular part of the behavioral continuum. States approach this term differently. In California, behavior disorder refers typically to those students whose present behaviors are disruptive to the learning process or social interactions of the group. The disruption often has considerably more effect on others than on the students themselves. The behavior may be learned but is less antisocial or purposely aggressive than that of socially maladjusted students. Often, the behavior is of emotional or neurological etiology associated with or similar to, but not necessarily, autism, hyperactivity, attention deficit disorder, Tourette's Syndrome, or traumatic brain injury. Acting out is generally situation specific rather than pervasive, may be under the student's operant control unless of neurological origin, and can be verbalized with regard to occurrence and purpose. The behavior differs from normal digressions in its intensity considering the circumstances.

Behavioral interventions are generally effective with students with behavior disorders. General education programs that incorporate social learning and behavior management approaches can successfully maintain many of these students in a regular classroom. Interventions designed by the student study team or in collaboration with special education staff can also assist in classroom success. In some settings, the school may have a regular class that follows a more structured format, or the student may benefit from opportunity classes and alternative education programs. When the disruption, inattention, or divergence becomes beyond the teacher's management in the regular classroom, it is essential that records and reports are available to assist the IEP team. As is often the case, behavior disorders are found along with other disabilities and require careful assessment to determine the relationship of the behaviors to a learning disability or other condition eligible for special education programs and services, such as serious emotional disturbance or autism.

## Serious Emotional Disturbance (SED)

These students are defined by the Code of Federal Regulations, Section 300.5(b)(8), California Education Code 56026(e), and California Code of Regulations, Title 5, Section 3030(i). Since federal and state law lists only very broad categories and parameters for identifying the student with serious emotional disturbances (see Appendix A, page 121), the literature needs to be referenced regarding more specific characteristics and guidelines (De Young, 1984; Tibbetts, Pike, & Welch, 1986; Weinberg & Weinberg, 1990). Based on federal and state law (indicated in bold face) and reference materials, the following are some examples of characteristics, symptoms, and conditions regarding the SED student.

1. Students with serious emotional disturbances are characterized by **an inability to learn which cannot be explained by intellectual, sensory, or health factors.** They may exhibit disturbances in reality awareness and display distorted reasoning, perception, and memory.

2. Another characteristic is the **inability to build or maintain satisfactory interpersonal relationships with peers and teachers.** They often have few or no friends, do not voluntarily play with others, may be extremely fearful of teachers or peers, and may avoid communication with them. Some may respond with excessive aggressiveness or withdrawal if others intrude upon their space. A student may sometimes resume behaviors that have been previously discarded, such as thumbsucking, bedwetting, and temper tantrums.

3. **Inappropriate types of behavior or feelings under normal circumstances** is another characteristic. These students may exhibit catastrophic reactions to everyday situations. Their emotions may be unpredictable, and they may show little ability to control their acting-out behaviors or temper tantrums. They may display inappropriate lack of fear, distorted emotional response patterns, extreme mood swings, unexplained rage, obsessions, bizarre delusions, visual and auditory hallucinations, inappropriate laughing and crying, and self-mutilation.

4. **A general pervasive long-term mood of unhappiness or depression** is another characteristic. Students may display an unexplained loss of interest in all activities, hopelessness, helplessness, or recurrent thoughts of suicide or death. They may have sleeping and eating disturbances, loss of energy, and inability to concentrate. They may have unexplained fears and apprehensions, may show no emotion, or display extreme anger or irritability.

5. **The tendency to develop physical symptoms or fears associated with personal or school problems** is another category. These include phobias, intense anxiety, irrational fears, and other symptoms of physical disorders which have no organic basis. These symptoms are not under obvious voluntary control.

***It should also be emphasized that a student may be both socially maladjusted and seriously emotionally disturbed.***

The student who is seriously emotionally disturbed must be differentiated from students in short-term crisis. Most students in crisis will return to normal emotional health once the effects of the crisis are removed, resolved, or otherwise abated. The school may play an important role in the resolution of short-term crisis. For eligibility for special education programs and services, the symptoms of serious emotional disturbance most generally have been present over a long period of time (six months is a rule of thumb) in most all life settings, including home and school, and prior interventions must have been attempted without success. The symptoms must be intense and impact on the student's functioning which may result in a significant change from the student's past behavior. Finally, there must be an adverse affect on the student's educational performance.

In law, only "social maladjustment" is excluded from the category of serious emotional disturbance. It should be noted that students with behavioral disorders may be eligible for special education as seriously emotionally disturbed or ineligible as socially maladjusted depending upon individual factors. It should also be emphasized that a student may be both socially maladjusted and seriously emotionally disturbed.

## Social Maladjustment

Socially maladjusted students often have intact peer relations particularly among a subculture with similar dissocial or antisocial values. These students are often portrayed as having an underdeveloped conscience and frequently engage in power struggles with authority figures. They are often independent, self-assured, and adroit at manipulating others to the advantage of their own desires or the shared desire of their subculture. Schools should avoid identifying students who are followers or members of a fringe group as socially maladjusted when they may be, in fact, behavior disordered or emotionally disturbed.

Socially maladjusted students may be characterized as essentially normal individuals who choose to break socially defined rules governing acceptable behavior. This behavior often translates into conflicts with authorities (teachers, school administrators, parents, and police) over control issues. Such students may seem to view themselves as normal with the right to behave as they wish. They usually blame others for their undesirable actions and seldom take responsibility for antisocial actions.

Socially maladjusted students may not achieve in school and some appear to disregard achievement believing school achievement to be "selling out" to the social system. Thus, lack of achievement becomes an extension of their struggle over control issues with authority figures and a logical consequence of resisting authority that results in limited or unobtained academic progress. For many of these students, this circle can be broken with educational programs designed especially to deal with self-concept and positive learning experiences.

***Schools should avoid identifying students who are followers or members of a fringe group as socially maladjusted when they may be, in fact, behavior disordered or emotionally disturbed.***

### Summary

In summary, it is not uncommon for Individualized Education Program (IEP) teams to deal with students who manifest characteristics of serious emotional disturbance, behavioral disorders, or social maladjustment. Often, the behaviors associated with behavioral disorders and social maladjustment overlap with those of emotional disturbances. It is the responsibility of the IEP team to determine the nature of the student's behaviors and to develop plans to assist the student. Good practice dictates that the IEP team consist of individuals who have expertise in all areas which contribute to the emotional status of the student.

## Identification and Assessment

As discussed previously, the school staff, particularly the student study team, is responsible for providing prevention services to students at risk of becoming seriously emotionally disturbed long before a referral for a formal assessment is made. These prevention services may include counseling and classroom consultations by counselors, school psychologists, social workers, consultants in classroom management, or other qualified individuals. Prevention will also include classroom modifications such as improvements in the quality of the academic instruction or the introduction of curriculum or skill training to address specific deficits in social skills, classroom behavior, or parenting strategies, as well as involvement in non-school services such as youth groups, local child guidance clinics, and mental health services for early intervention. Prevention may also result in modified school hours, support services to teachers, school mental health services, and many other creative services.

Prevention services are initiated, reviewed, revised, and evaluated over an appropriate period prior to initiating assessment for special education. If substantial efforts at modification of the regular school program fail to meet the needs of students who are at risk and have been adequately documented, a referral for assessment is made. This period of program modification is not a stalling period, but rather a team effort of the family, school staff, and others to modify the environment to meet the needs of the student at risk of serious emotional disturbance.

## Purpose of Assessment

The purpose of assessment is twofold: (1) to determine the nature and extent of the student's needs in order to decide on the appropriate prevention program, regular or special education interventions, and/or special education and related services that will meet those needs, and (2) to determine the individual needs of the student in order to develop or specify unique instructional or treatment approaches, interventions, and modifications that should enhance the student's opportunity to profit from education. Both purposes are addressed through multidisciplinary assessment and become the basis for designing instructional and treatment objectives necessary to meet IEP or classroom goals.

Special educators frequently complain that assessment reports directed at determining eligibility often provide little educationally relevant information useful for planning and implementing instructional or treatment programs for students with serious emotional disturbances. Labels for the student's handicapping condition do not provide the information necessary to plan specific educational and intervention programs. During assessment, information is collected that is relevant for designing each student's individualized educational program, for selecting needed services and possible placement options, and for identifying the school and community resources needed for an appropriate educational and treatment program. This information serves as the basis for the initial planning of educational and behavioral interventions, but it should also be used as a benchmark for comparing the effectiveness of the interventions when measuring the progress of the student. If for some reason the IEP team's review of the assessment data determines that the student is not eligible for special education services, their assessment information must be provided to the general education program serving the student in order to enhance coordinated efforts to provide an appropriate education for the student.

A comprehensive assessment includes consideration of appropriate, nondiscriminatory and least restrictive measures for each of the dimensions assessed. Appropriate assessment requires the involvement of qualified, skilled, and knowledgeable examiners and the utilization of instruments and procedures that evaluate significant factors related to learning and emotional development. Assessment results are described in written reports designed to assist the team in making

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decisions that identify the least restrictive and most appropriate educational setting and interventions.

Because the student's emotional health is at issue, assessment of students referred for consideration of SED services is usually more extensive than ordinarily required for special education. The IEP team member conducting the mental health portion of the SED assessment must have training and experience in assessing emotional functioning using a wide variety of instruments and procedures.

### Assessment for Determining Student Needs

In conducting an SED assessment, it is mandatory that one or more of the required conditions contained in the Individuals with Disabilities Education Act (IDEA) be determined and the nature of social maladjustment be evaluated. In order to evaluate the student in light of these requirements, the psychoeducational assessment should include all of the following areas (DeYoung, 1984; Tibbetts, Pike, & Welch, 1986):

**HEALTH BACKGROUND**
Developmental history, emotional history, medications, major illnesses and hospitalizations, current health status

**FUNCTIONING IN THE HOME/COMMUNITY**
Socioeconomic background, language, cultural and educational background, family experiences and constellations, including losses and/or stresses

**FUNCTIONING IN SCHOOL**
School history including attendance, achievement and adjustment, current achievement, adjustment and behavior in academic and nonacademic situations

**BEHAVIORAL ASSESSMENT**
Evaluation of the student's behavior in the context in which it occurs; hypothesis of its purpose or communicative function; exact description and definition of the problem; identification of significant background information that relates to the problem; description of developmental factors that relate to the problem such as the student's cognitive level, learning style, communication style, and mobility; and analysis of what happens before and after the behavior occurs

**SOCIAL-EMOTIONAL STATUS**
Assessment of SED conditions to include those specific tests and techniques validated to determine the extent of those conditions (e.g., specific assessment of depression)

**PREVIOUS EVALUATIONS**
Previous assessments and information from records, parents or outside agencies that relate to the student's current and/or related problems

**PRIOR INTERVENTIONS**
Analysis and documentation of the student's response to all known behavioral, emotional, and educational interventions carried out by school personnel, parents, other public agency personnel, and private professionals

**INTERVIEWS AND SELF-REPORTS**
Assessment data may also be generated from the following: structured self-report instrument completed by the parent(s) or guardian, teacher (if secondary, all teachers); self-report instrument completed by student; structured interview(s) with student to obtain clinical data; structured observation(s) of student in different settings; interview with parent/guardian; interviews with school personnel who may have interacted with or have observed the student (teachers, administrators, support staff)

**PERVASIVE NATURE**
The presence of the condition and the pervasiveness in all of the student's environment is cross-validated by observation, interviews with parents, teachers and staff personnel and others who may have interacted with or observed the student in the community. A review of the observations of the examiner and others in determining that the condition is pervasive throughout the student's environment

**EDUCATIONAL PERFORMANCE**
A determination that the condition adversely affects the student's educational performance. This is not restricted to test scores, but includes the student's broader ability to function in the learning environment. Will this student be able to apply the instruction to be gainfully employed? Is the shy withdrawn behavior overlooked because it disturbs no one? Are social interactions inappropriate although homework is adequate?

**CULTURAL DIFFERENCES**
A review of the observations of the examiner and others in determining that the conduct is not due to cultural, ethnic, or language differences.

The assessment information listed above can be obtained through a comprehensive review of records, including school, health, academic progress and disciplinary history, previous assessments, and information from parents and outside agencies that relate to the student's problem and analysis of documentation of the student's response to interventions carried out by staff and parent(s). Health and developmental history, sociocultural background/family history, and current health status are also important sources of information.

## Assessment for Determining Instructional Interventions

Assessment is critical in planning for instruction and treatment. Informal and formal assessment procedures are designed to provide a comprehensive picture of the student's current functioning in all areas. Specifically, information must be obtained regarding a student's academic skills, cognitive abilities and development, language and communication skills, sensorimotor and perceptual functioning, self-help and adaptive behavior, social, behavioral and emotional functioning, pre-vocational or vocational skills, and cultural and environmental factors affecting a student's development.

The following list includes information on types of assessment instruments and data useful for planning appropriate educational/treatment interventions.

**INTERVIEWS WITH THE STUDENT, TEACHER, PARENT(S), AND OTHER CONCERNED INDIVIDUALS**

An assessment must begin with a clear picture of the child and his or her problems from the perspective of the significant individuals in the child's life, as well as from the child's own perspective. Despite problems with the objectivity of interview data, many techniques exist for obtaining valid and reliable information through the skilled use of clinical interviews (Sattler, 1988).

**WORK SAMPLE ANALYSIS**

Samples of the student's work are studied to evaluate correct and incorrect responses. This can include work from any subject area, but it does require that the evaluator have a knowledge of the typical types of errors that may occur. It is especially useful because it provides data on the "number, types, and patterns of frequently made errors and successes. Because of the clear connection to the curriculum, the potential usefulness of the data is high. A teacher can use the information to establish goals and identify ways to modify instruction" (McLoughlin & Lewis, 1990, p. 9). It is vital to evaluate what role curricular or instructional factors may play in a student's inability to function effectively in school.

**OBSERVATION**

Data collected through observation can be very valuable in assessing academic or social skill problems, yet it is a technique that is frequently overlooked (or underused) in the initial assessment of students. This data can indicate the presence of classroom behavior problems, environmental factors that contribute to the problem (e.g., inappropriate actions on the part of other students or adults), the continuance of the problem over an extended period of time and in various settings, and the response of the problem behavior to various interventions. Because it is generally conducted under natural conditions (i.e., in the classroom or home setting — not in an isolated test cubicle) the data regarding the context, purpose, frequency, accuracy, and duration of behaviors is crucial in designing and evaluating interventions.

### CURRICULUM-BASED ASSESSMENT

This technique is designed to determine the instructional needs of students based upon their ongoing performance in existing curriculum. Often these measures are designed by teachers and assess such things as timed measures of reading rate or spelling accuracy and serve to assist in both planning and modifying instruction and in monitoring its effectiveness.

### CRITERION-REFERENCED ASSESSMENT

The student's performance is compared to a criterion level of desired skills rather than to that of other students. This technique is used to determine if students have mastered specific academic or social skills by comparing their performance to a carefully designed specification of the behaviors required to demonstrate mastery. The data gathered with this technique can serve to establish initial instructional needs or to evaluate student progress. These are frequently developed by the educator, but several are available commercially.

### CHECKLISTS AND RATING SCALES

These instruments gather information in a variety of formats. They can be helpful in gathering information from parents, students, or professionals regarding the academic or social skill performance of students. Many excellent behavior rating scales exist that provide reliable and valid information regarding children's emotional and behavioral adjustment.

### NORM-REFERENCED ASSESSMENT INSTRUMENTS

Administered in a standardized manner, these instruments provide information on the student's performance compared to a norm group of age peers in areas such as (a) intelligence or cognitive development, (b) general academic achievement, (c) measures in more specific academic areas such as mathematics, reading, language, etc., or (d) patterns of social or classroom behavior. While data from these instruments seldom translates directly to developing interventions, they do assist in identifying areas that need further assessment for the student. It is important to note that these test results are sometimes limited in their ability to generalize to students with serious emotional disturbances because normative samples often do not include these students, the students have often not received adequate instruction in the domains tested, and the reliability of the data is questionable because the students may lack the skills necessary to function well in the test setting (Lewis, 1988).

In the assessment process for educational planning, the data obtained must relate to (1) the specific measurable performance characteristics of the student, (2) qualitative information on student capabilities as well as on the areas of difficulty or delay, (3) student's response to previous interventions, and (4) a comparison of student skills with the academic, social, and/or study/work skill expectations in school, home, and community environments. Knowing a student's grade level in math provides much less useful information than being aware of the student's knowledge of basic math facts or the student's ability to solve problems requiring regrouping. This also holds true for data on performance in the social skills and study/work skills area. It would assist the teacher to know whether students are able to interact effectively with peers or are capable of following verbal directions and the percentage of time that they perform these skills appropriately. Accurate and pertinent data collected at this stage will greatly assist in the initial development and subsequent evaluation of appropriate educational and treatment plans. As with any other assessments in special education, the information obtained must be presented in writing so that it can be clearly understood by all individuals who may work with the student.

It is also crucial that the three limiting criteria contained in the federal definition (over a long period of time, to a marked degree, adversely affecting educational performance) be explicitly evaluated and addressed in the assessment report.

The assessment process may be circumvented by teachers and administrators who want problem students out of the classroom. This places pressure on the IEP team and may result in rushing the IEP team to unsubstantiated and inappropriate judgment in what is a very complex assessment and decision-making process. The special education staff need to assist general education administrators and staff in understanding the eligibility criteria and the necessity to make program modifications and prevention efforts in order to accommodate students in the least restrictive environment. It is best to review the SED criteria and assessment process with each school administrator annually after a short inservice as this may help to reduce the staff's desire to exclude disruptive students without prevention or modification efforts. This approach is particularly effective if it is conducted early in the school year at each school site.

### Considerations in Assessing Diverse Students

Students who are culturally, ethnically, and linguistically diverse may view the school from a different perspective when compared with their mainstream peers. Correspondingly, the way in which they are perceived by school personnel may underscore their cultural differences. Factors that may vary from what is characterized as mainstream values, expectations, and behaviors are:

- manner in which students adjust to the school environment
- physical appearance
- the way in which they respond emotionally
- self-concept
- the presence or absence of a competitive spirit
- attitudes toward independence and achievement
- management of aggression
- coping mechanisms
- family interactions
- attitudes toward school achievement
- peer relationships
- the manner in which they adapt within their community

Information regarding these differences can only be obtained by becoming familiar with the family and community environment of the individual student being assessed. While it is important to use knowledge about a student's ethnic, linguistic, cultural, and socioeconomic background as a general rule to guide and inform overall assessment, one should always be mindful of the individual child's unique characteristics, situation, symptoms, defenses, and coping strategies. All students are to be assessed in their primary language, including students who speak limited English. Standardized scores can not be used if the student's ethnic group was not represented in the norming sample upon which the instrument was standardized. Interviews with the family also must be conducted in their primary language.

The possibility that the referral of a minority student was based in any way on ethnic, linguistic, or cultural diversity must be addressed and ruled out during the assessment, well before the question of eligibility is assessed.

Schools are indeed fortunate if they have members of their IEP team experienced and qualified to interpret culturally diverse students. Most schools will need to depend on assistance from interpreters of both the language and the cultural nuances of minority students. Schools may also utilize members of clergy, university staff, or other volunteer community members to act as language and cultural interpreters. The IEP team members conducting student assessments need to work carefully with the interpreter in order to mitigate cultural bias as much as is possible in the assessment process.

## SECTION 3

# EDUCATIONAL INSTRUCTION AND SERVICES

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# EDUCATIONAL INSTRUCTION AND SERVICES

Improving the effectiveness of California programs serving students with serious emotional disturbances (SED) requires a review of the instructional and related service elements of these programs. The effective translation of these elements into program content and procedures plays a major role in determining the success of programs designed to meet the needs of students identified as SED. These students generally perform below the level of their peers in academic achievement, and they have other significant behavioral deficiencies or excesses; both are areas that require carefully planned and effectively delivered instructional and treatment interventions. Students with serious emotional disturbances have not developed the essential attributes to perform effectively in a normalized environment, and they require the specific instruction and support needed to develop and maintain these skills.

The primary instructional and educational services discussed in this section relate to the following:

- Procedures for identifying and selecting appropriate goals and objectives for the IEP
- Determining placement and related services options from a continuum of services in SED programs
- Descriptions of placement and related services options, organization and delivery of services
- Instructional interventions
- Evaluation of program effectiveness

## Determining Appropriate Goals and Objectives

The IEP for a student identified as SED is composed of the same essential elements required for the IEPs of students with other handicapping conditions (e.g., present level of performance, annual goals, objectives). The nature of the data considered in developing the IEP may be different than that used in other areas because it often involves the input of an expanded set of professionals (e.g., clinical psychologists, psychiatrists, social workers, mental health professionals) and frequently includes data provided by agencies outside the school (e.g., primarily Mental Health, but also California Children Services and Regional Centers in the case of dually diagnosed youngsters: Developmentally Disabled/SED. It is also important that the IEP reflect the input of parents and the student (when appropriate). When the Department of Mental Health is involved in the case (such as Chapter 26.5 referrals), the assessor for mental health will provide a written report regarding the student's social/emotional status, a statement regarding eligibility for mental health services, and a recommendation for the level of service intervention required. These reports must be detailed enough to reflect a specific treatment and to determine program planning and the implementation process. (See Section 4.)

***The collaborative process of the multidisciplinary team is even more critical in determining consensus on goals and objectives and other IEP decisions for the student with serious emotional disturbances as many community agencies other than the school may be involved.***

Much of the data needed to assist in developing an IEP for a student with serious emotional disturbances will be similar to that needed for other students with academic and behavioral problems. If the student study team process has effectively reviewed the use of the general education interventions and the multidisciplinary team report is comprehensive and accurate in regard to the relevant information needed to plan educational programs, the IEP team will be better able to meet their responsibility of determining appropriate goals, objectives, required services, and placement for the student. The collaborative process of the multidisciplinary team is even more critical in determining consensus on goals and objectives and other IEP decisions for the student with serious emotional disturbances as many community agencies other than the school may be involved.

Goals and objectives for the student should flow from the "present level of performance" description. The goals and objectives become, in effect, the basis for a treatment plan for the student and should be age appropriate and culturally sensitive. Their development requires that the IEP team address both the student's academic and emotional/social needs as they relate to school success, community survival, and vocational readiness. The IEP should state how the accomplishment of the goals will be measured and who will be responsible for this evaluation. The student's parents are involved as active partners in the development of their child's IEP. The student's progress should be evaluated periodically throughout the year with a record of the date of the assessment and the resulting performance levels achieved. This information on performance levels provides the basis for creating subsequent goals and objectives.

## Considerations in Developing Goals and Objectives

The development of goals and objectives for students with serious emotional disturbances requires that the IEP team take into account a number of important considerations such as the following:

1. Goals for behavioral, social, and emotional development should be given a high priority and treated as a curriculum area. Appropriate social skills curriculum and mental health and related services need to be provided on a regular basis to give direct instruction and support in the development and maintenance of these skills.

2. Goals in academic instruction should reflect the district's core curriculum at the student's current level of performance. These academic skills need to be taught, improved, or maintained because performance at or close to grade level is essential when considering students as candidates for mainstreaming or exiting the SED program.

3. Goals in upper elementary and secondary programs should also focus on providing instruction in the area of study/work skills (e.g., arriving on time, following directions, organizational skills, completing tasks as assigned and on time), vocational skills, and community independent living skills.

4. Secondary programs should include goals that address movement from class to class and appropriate performance in unstructured activities such as homeroom, nutrition, lunch, and extracurricular activities.

5. Limited English proficient or non-English speaking students must have an English-as-a-second language (ESL) goal in the IEP. The special education teacher is typically responsible for collaboration in this instruction.

6. Many students with serious emotional disturbances require goals related to interpersonal and behavioral control problems. They may also receive designated instructional services (DIS) (e.g., school, individual, small group, or parent counseling) and/or mental health services to assist in this area.

7. Additional DIS services such as language and speech, adapted physical education, occupational and physical therapy, and services for students classified as deaf/hard of hearing, visually handicapped, physically handicapped need to be noted in the goals and objectives if the student requires these services.

8. Students qualified for programs for the deaf, visually impaired, other health impaired, or orthopedically impaired may qualify for low incidence funds to purchase specialized materials to meet their educational needs. Inclusion in a low incidence group needs to be stated in the body of the IEP.

9. The IEP must include probable time lines for implementation of sequential goals and objectives.

10. Objectives need to be specific, clear, and derived from a task analysis.

11. Objectives must address transition activities, especially moves into the general education program and work experience environments, as appropriate.

An additional consideration that must be taken into account when completing the IEP relates to the portion of the student's school day that will be spent in a general education program. The student should be placed in a general education setting for a portion of their school day if they are able to exhibit and maintain the appropriate behaviors required in that setting. This area must be considered by the

IEP team and the conditions under which this will occur specified in the IEP. When this integration is planned, it is important that someone be responsible for carefully selecting the appropriate general education classroom teacher. Arrangements should also be made to provide support or consultation services to the student and the teacher to ensure that the student's educational needs are met and to monitor performance in academic and behavioral areas on a regular and ongoing basis. Special importance should be placed on developing work experience goals and objectives in community settings.

## Determining Appropriate Placement and Related Services Options

To adequately address the diversity and severity of educational and developmental needs demonstrated by the broad range of students identified as SED, access to a continuum of specialized instructional and related services is mandated for all students with handicaps. It is also important that the placement be in the least restrictive environment (LRE) in which the individual student with serious emotional disturbances may be appropriately educated.

The LRE options available for each IEP team should range from the general education classroom setting with integrated support services and periodic monitoring to that of a residential facility with 24-hour supervision and a total therapeutic environment. At times, there can be an over reliance on geographic location in the interpretation of LRE. Frequently the LRE principle can serve as a guideline for effective practices within a school setting. In other cases, because of the nature of its program, resources, flexibility, tolerance level, etc., settings that are geographically distant from the public school may be the "least restrictive" for an individual with a disability. LRE needs to be defined in terms of individual needs matched with the appropriateness of the resources that can be made available in a setting.

### Placement Criteria

As the IEP is being completed, the IEP team must determine the specific special education and related services needed by the student and identify the type of program and placement setting which best meet the goals and objectives stated in the IEP. Finally, the team will state when the recommended service or program is to begin and when the next IEP meeting will be required. It is important to consider the following reminders provided by Strickland and Turnbull (1990, p. 289) regarding the criteria for determining the placement of students.

**Phoenix School**

*Combining a special education and mental health day treatment program, the Phoenix School program provides an example of how collaboration can work to provide a setting for students with intensive needs that is less restrictive than a residential treatment program. For these students, this is the "last chance" to succeed in a public school setting. The school is co-sponsored by the Office of the Ventura County Superintendent of Schools and the Ventura County Mental Health Department.*

*Funding from Chapter 26.5/AB 3632 provides two special education classes staffed with a teacher and an aide in each classroom. Other staff include two mental health social workers, a mental health counselor, a mental health coordinator, a principal from Ventura County Superintendent of Schools office, a part-time psychiatrist, and a part-time social skills trainer.*

*In most cases, the students at Phoenix are able to return to their home districts — an even less restrictive environment, in one year.*

The Individuals with Disabilities Education Act clearly establishes the basic criteria on which placement decisions are to be based. Public agencies are required to ensure the following:

I. Each student's educational placement is based on his or her IEP.

2. To the maximum extent appropriate, students with disabilities are educated with students who do not have disabilities.

3. A full continuum of alternative service delivery models is made available to the extent necessary to implement the IEP.

4. The student is placed in the school he or she would attend if not disabled, unless the IEP requires otherwise, in which case the placement must be as close to the student's home as possible. The IEP must document the reasons for recommendations which place the student in a more restrictive environment.

5. Each student's placement is determined at least annually.

California regulations require that the IEP team consider the effect of the placement of students with serious emotional disturbances upon other students in the class and assure that the student's IEP is "compatible" with the program of the class.

All of these considerations are sometimes overlooked by IEP teams because of reasons such as: "Oh, let's put him in our SED class" (regardless of whether that class is appropriate or not); "All our programs of one type are full;" "The principal does not want students with serious emotional disturbances on his campus;" "The district has not been able to obtain another special class teacher." Considerations such as these do not abrogate the need to provide the student with the service or program that is appropriate for that student.

## Placement and Related Services Options

The following is a brief description of several types of program options provided for students with serious emotional disturbances. (See Section 4 for additional descriptions of community services available.)

## Integrated Settings

Within the integrated settings, both the general education classroom teacher and the special educator are responsible for working with the parents and providing for the education of the student with emotional disturbance. However, it is the general education teacher who is responsible for working with the major part of the instructional, as well as the social/emotional, programs. They are often asked to work with parents, communicate the student's problems during staffings, maintain anecdotal records of all behaviors, and consequently assist in the development of program modifications in the IEP process.

In this model the special education staff members frequently function in a support role to the regular classroom teacher. This collaboration requires a unique set of skills in which consultation may be provided by a variety of individuals. The thrust of this role is for the consultant to collaborate with the teacher or parent as co-workers. The consultant's focus is to assist others in meeting the needs of the student and to help develop the skills necessary to accomplish this goal. The consultant's role is *not* to simply tell them what to do without input on their part. To be effective the consultant needs listening and communication skills, understanding of one's own style as well as the styles of others, and also to maintain a role of credibility and openness while participating as a team member. All staff will need specialized training to put into practice effective collaboration.

Integrated programs include the following:

**Full-day regular class placement with consultation to the teacher.**

This integrated setting involves placement in a general education program with appropriate resource services (e.g., Resource Specialist Program (RSP) assistance regarding academic instruction or behavior management and help in communicating with the parent, counseling through the school psychologist, school counselor, or mental health professional).

**Part-day general education placement and placement in appropriate part-day alternative educational settings.**

The teacher may receive the same type of service noted in the previous category, but the student also receives services from the special educators. This may take place in or out of the regular classroom, but the general education teacher maintains the primary responsibility for the student.

**Part-day placement in special class and part-day placement in general education program.**

In this type of program, the student with serious emotional disturbances spends the majority of the day in the special class but joins the general education program to participate when appropriate.

## Protective Settings

When the student's needs are more intensive, additional services may include interagency services. There are many options that need to be considered in making placement decisions. Along the continuum of the more protective settings are programs that may be located within the main school campus, on the perimeter of the campus, in a separate facility away from the school campus, in a nonpublic school, within a residential and hospital setting, or through a home education program.

Factors that contribute to determining program location include (1) the need for a highly trained interdisciplinary staff and support personnel (increased therapeutic interventions are often found in more restrictive, protective settings), (2) classroom location that enhances appropriate peer mainstreaming options, (3) the need for containment, and (4) adequate classroom and therapy space that accommodates both individual and group work. Frequently, factors such as the severity or intensity of the behaviors of students in the program, special and regular classroom enrollment, and the attitude of the receiving campus dictate the placement of programs for students with serious emotional disturbances. These and similar factors are not legally permitted to dictate access to a level of LRE that is required; nevertheless, they do influence these decisions on an everyday basis. It is the program administrator's responsibility to assure that such issues do not influence placement decisions.

Within protective settings, the special education teacher in the program generally maintains the primary responsibility for the educational program of the students with serious emotional disturbances, and the regular classroom teacher has minimal or no contact with the student. Specialized curriculum and methodology are used in behavioral management systems designed to develop appropriate behaviors. Instruction should be provided for these students in academic, social, and study/work skills with an emphasis on developing functional living skills for older students. In addition to the basic instruction provided, these students may also receive designated instructional services (DIS) counseling through the school psychologist or mental health clinician and have access to the full range of other DIS services. The overall goal of such programs is often (1) to modify the student's skills and behavior to support participation in a less restrictive environment, (2) to provide the student and family with new skills to increase success at school and home, (3) to develop social/emotional well-being, and (4) to enhance academic or functional skill growth.

As with the integrated program model, there are also advantages and disadvantages in protective settings. Positive aspects cited for the protective settings model include having greater flexibility in curriculum offerings that focus on skill development in areas not generally addressed by the general education curriculum, integrating the student and family therapy components, maintaining greater consistency within and across the student's environments, limiting the student's need to relate the different (and often inconsistent) guidelines and expectations of several adults, and providing a more consistent environment in which to monitor progress systematically. Protective settings attempt to adhere to the principle of LRE by building in provisions for all students to have equal access to (and to be actively involved in) school facilities, equipment and materials, and extracurricular activities or programs to the fullest extent possible and as appropriate to the needs of the individual student. One disadvantage for the protective settings model is the transportation of the student to the site. Transportation costs can be exorbitant. Another major concern regarding protective settings is that they can reduce (or eliminate) the access to models of normal behavior since the student is not with nondisabled peers. They are also more likely to be exposed to students who exhibit severe displays of disturbed behavior.

The separation that exists in protective settings contributes to management as well as programming difficulties when transitioning students back to a least restrictive environment once they have maintained significant emotional/behavioral progress in the protective setting. To remedy this problem, transition classrooms have been established to create settings approximating the regular classroom environment as related to social interaction, task completion and expectations, and independent functioning but with more relaxed expectations imposed on the students until they become adjusted to the accepted limits of behavior in the regular school setting. Other programs have provided a continuity of support services that "follow the child" across settings to facilitate and maintain social and emotional growth during transition. Still others provide the student with support personnel within the classroom to assist in the adjustment by monitoring and reinforcing the student for appropriate behavior. Another option is to enroll the student concurrently in both programs. The minimal approach to transition may involve introducing the student to instruction in the general program and actively monitoring progress in each setting. Protective settings include the following:

**FULL-DAY PLACEMENT IN SPECIAL CLASS**
The special class is typically located on a school campus and provides a special teacher and classroom aide(s). The class provides an intensive educational program designed to develop skills that will prepare students for a return to the mainstream and to function in the community.

**FULL-DAY PLACEMENT IN SPECIAL CLASS WITH A DAY TREATMENT PROGRAM**
This special class is also typically located on a school campus and provides a special teacher and classroom aide(s). Within this type of placement, the services provided in the traditional special class are coordinated with a day treatment program. The day treatment model is designed to meet the needs of the student with serious emotional disturbances who has not responded to less intensive educational environments. This program considers work with the family as critical to the success of the student; therefore, motivation and willingness of the parent or guardian to participate regularly in the child's treatment program is also determined in the assessment for admission. Many districts are exploring the idea that by providing an effective integration of intensive therapeutic and educational services in the same setting to the student who lives at home with their family or within the foster care or group home family, a more positive and cost effective alternative can be offered rather than hospitalization or residential placement.

Overall, the day treatment program strives to provide a therapeutic environment by providing individual group and family therapy, psychiatric and medication services, crisis intervention, and a range of therapeutic activities integrated with a special education classroom. The program maintains a supportive and accepting community in which students can (a) learn to identify and express thoughts and feelings appropriately, (b) give and receive feedback from staff and peers, (c) interact with others in an effective, socially appropriate, and satisfying manner, and (d) experience a sense of accomplishment in a variety of therapeutic activities and academic experiences. The focus is on improving self-awareness, self-esteem, and coping strategies; enabling the student to function as a member of the peer group; and developing academic and realistic prevocational, vocational, and community living skills. An interdisciplinary team consisting of educational and clinical personnel meet weekly to discuss strategies, problems, and new approaches for each student. Communication is the vital link between program staff, parents, and student for enhancing and maintaining consistency throughout the various environments of the student.

**FULL-DAY PLACEMENT IN SPECIAL SCHOOL (PUBLIC AND NONPUBLIC)**
Special schools, both public and private, have also been supported as meaningful alternatives within the continuum of education programs offered to students with serious emotional disturbances. Typically, these programs are without a day treatment component. The staff is generally interdisciplinary in nature and the student/teacher ratio is low. A full range of DIS services is available and additional resource personnel such as a behavior specialist exist on site. An expanded specialized curriculum is implemented, and the learning environment is highly structured and often psychoeducational in nature. Overall, an attempt is made to create and maintain the type of therapeutic environment described above throughout the duration of the program.

Enrollment in both a public and nonpublic school is also possible for some students. This option provides community placement in a specialized learning environment with intensive educational and support services as an alternative to more restrictive (i.e., residential) placement.

**FULL-DAY PLACEMENT IN SPECIAL SCHOOL (PUBLIC AND NONPUBLIC) WITH A DAY TREATMENT PROGRAM.**
This option would combine the features of the day treatment program and the placement in a special school that are described in the two previous options.

**FULL-DAY PLACEMENT IN RESIDENTIAL FACILITY (PUBLIC AND NONPUBLIC)**
When the emotional disturbance becomes so debilitating that the student is unable to benefit from the public educational system or is unable to function among peers, or the resources of the less restrictive settings described above are insufficient, residential or hospital placement may be a consideration. Education and mental health jointly recommend such placement to the parents through an expanded IEP team process. Such placement is voluntary on the part of the parents, and they retain full parental rights to consent to (or deny) residential placement. The student's emotional, as well as educational progress, are reviewed regularly by both mental health and educational case managers. When appropriate, the student is transitioned along the continuum of alternatives outlined here to the public or private school sector. (See Section 4 for further discussion of individuals hospitalized for emotional illness.)

**HOMEBOUND OR HOSPITAL PLACEMENT.**
Students educated in these settings are most frequently individuals who are unable to physically function on a school campus or who have experienced a recent crisis. Homebound students are most often served by an itinerant teacher who makes periodic visits to provide the instruction and materials needed by the

students. Typically, a hospital placement offers a special class or itinerant teacher. Services from therapists and others may also be provided for students served in these models. Students are not generally served in these settings for long periods, but are moved to less restrictive environments as they improve in their ability to function more appropriately in school or social settings.

Whenever a student is recommended for placement in a more restricted setting, the IEP team must determine and document the reasons for the recommendation. These reasons must identify the positive effect of the delivery of services in the more restricted placement and not be based on a lack of options. LRE is a right under federal law.

***Whenever a student is recommended for placement in a more restricted setting, the IEP team must determine and document the reasons for the recommendation. These reasons must identify the positive effect of the delivery of services in the more restricted placement and not be based on a lack of options.***

## Related Services

The specially designed instruction provided by special education programs can be supplemented by related services such as "transportation and such developmental, corrective, and other supportive services as required to assist a handicapped child to benefit from special education" (Federal Register, 1977). The nature of the student's disorder, individual needs, etc., should be carefully considered by the IEP team in determining the necessary services. The following describes related services typically provided for students with serious emotional disturbances:

**PSYCHOLOGICAL SERVICES**

These may include a variety of direct and indirect services provided by an appropriately qualified and licensed or credentialed person. Such services typically include individual counseling, group counseling, and family counseling. In addition to providing individual and group counseling, included are such interventions as social skills programs, affective education programs, interpersonal problem solving skills training, moral education programs, guidance or counseling groups, crisis intervention, containment of assaultive behavior, and behavior management consultation.

The delivery of counseling services generally takes place in one of three locations: (1) on campus, within the classroom as well as in the counseling office, (2) in other locations throughout the campus where the need may be greatest, or (3) off campus, at the mental health clinic or satellite site. Factors to consider in adequately providing these services include providing quiet, sound proof environments in which to conduct the counseling sessions; providing adequate space to accommodate both individual as well as group work; ensuring privacy for the student entering and exiting the counseling room; transportation to and from the mental health clinic satellite; coordinat-

ing this service with other educational services received; and maintaining regular communication between all parties at school, the clinic, and home. These services may be provided by authorized public school personnel or by appropriately licensed professionals.

Clinical psychologists with training and/or experience working with students with serious emotional disturbances can be a powerful adjunct to the SED program. Frequently, they operate as a member of a collaborative team along with the school psychologists, counselors, and others. They may also provide staff development and case conference presentation on individual students. School counselors, psychologists, and social workers may also provide these services. This format has allowed classroom staff to have enhanced understanding of some of the underlying issues for these students, as well as enabled teachers to recognize the relationship of these issues to classroom interaction and performance.

### PARENT COUNSELING AND TRAINING

This service typically includes individual counseling for one or both parents, parent surrogates, or significant family members; group counseling; family counseling; parenting classes or training groups; or parent consultation. The importance almost universally attached to the parents' role in successful intervention with students with serious emotional disturbances makes these services especially appropriate. The role for parents in this context differs from the parent as IEP team member, to one as active participants in their child's counseling program. Although the counseling is appropriately provided by professionals with the same credentials or licenses indicated for psychological counseling for the student, the counselor must have special competence in parenting and family dynamics. Training in parenting, on the other hand, may be provided by any professional with appropriate training to provide that service (e.g., a teacher; school counselor; Marriage, Family, Children Counselor (MFCC); school psychologist).

### SOCIAL WORK AND RESOURCE COORDINATION SERVICES

One of the characteristics associated with the life of many students with serious emotional disturbances is a dysfunctional family system and a dysfunctional social service system. In addition to parent counseling and family counseling, social workers are prepared to contact and orchestrate community resources as a family support system. The most appropriate provider is a school social worker or a Licensed Clinical Social Worker (LCSW), although these services may be provided by any appropriately trained, qualified professional.

### LANGUAGE AND SPEECH SERVICES

Depending on the nature of the student's emotional disorder, language therapies may be a component of the treatment program. Students with serious emotional disturbances often exhibit a variety of communication disorders and delays. The provider should be a credentialed language, speech and hearing specialist (LSH), or a credentialed teacher with a communication handicapped (CH) specialist authorization, or a licensed speech/language pathologist. Speech and language services can be provided in a clinic office or directly within the classroom (e.g., the specialist acts as a classroom resource conducting group instruction in speech and language, etc).

### ADAPTED PHYSICAL EDUCATION

Students who demonstrate significant difficulties in physical movement and coordination may qualify for specialized, or adapted, physical education services provided by a credentialed, adaptive physical education (APE) teacher. Often students with serious emotional disturbances who lack the perceptual, social, and behavioral skills to participate in regular physical education, may benefit from these individual, small group, and consultant activities.

### VOCATIONAL EDUCATION AND CAREER DEVELOPMENT

It is especially important to provide a specially designed vocational education program for high school students with serious emotional disturbances. Although many may be able to participate in regular vocational education options with assistance (e.g., work study or Regional Occupational Programs), those with chronic and severe personal, interpersonal, and behavioral difficulties will require specific vocational and community training if they are to function with any degree of autonomy after leaving the protective environment of the school. This service can readily provide a bridge to continued support through public agencies such as Vocational Rehabilitation and Mental Health. Providers include credentialed specialized teachers, general and special education teachers, school counselors, supported work specialists, teachers, and teachers of traditional classes.

## Transition

Transition includes both transition from a "more restrictive" to a "less restrictive" environment and from a school to a community setting. Transition services include vocational training, adult and community independent living skills, and follow-up support services in the adult service system. Often students move from one setting to another with little or no preparation, and there may be no logical connection or exchange of information between placements. If appropriate transition services are developed by teachers, counselors, and administrators, student success is greatly facilitated.

Two good practices, if followed, will assist in planning and maintaining transition services. First, careful consideration must be given to writing IEP goals and setting measures of attainment. Clear milestones for both academic and behavioral achievement must be stated in the IEP. Second, there must be a clear understanding of exit criteria from special education and how the student will transition to either the general education program or the community. This can be developed on both an individual and district program basis.

Any changes in placement (including mainstreaming) should occur gradually. When possible, mainstreaming or placement changes should occur for a portion of the day before a full day change is made. The student with serious emotional disturbances needs much support in order to deal with change. It can be helpful to have the familiar environment available to "fall back on" while making the transition. Summer school sessions are shorter and provide a good time to attempt increased mainstreaming.

Too frequently services have been withdrawn when students were mainstreamed or changed to a different special education class. However, during a transition there is a tremendous need for continuing support to the student and the new service personnel. There is a need to structure and systematize transitional programs that include transitional support services regardless of the student's label. For example, it is recommended that counseling services be continued, preferably with the same counselor. It would be helpful to have ongoing group counseling sessions for students who have been mainstreamed from an SED class. There is also a great need to continue monitoring students who have been mainstreamed or transitioned to a "work" setting. It would promote student success in their mainstream setting if the transitioned student with serious emotional disturbances was assigned to a case manager or a job coach.

There is a need for providing support to the new professional or employer who works with the student. For example, it is important for meetings to be scheduled between the student's current teacher and the new special education or general education teachers to discuss the child's history, behavior management, and academic strategies. It would be helpful if the current teacher could be available as a resource to the new teachers for at least a year following mainstreaming or placement change. This necessitates a team approach to working with students with serious emotional disturbances that allows for a teacher to have release time to work with other teachers. In the work setting, job coaches can provide the ongoing link between the employer, co-workers, and the transitioned student's school and home. Job coaches have proven to greatly enhance the success of students with serious emotional disturbances on the job site.

A post-high school transition plan must be developed each year after the student with exceptional needs reaches age 16 (or age 14 as appropriate). Regulations based on the Individuals with Disabilities Education Act of 1990 provides guidelines for developing transition plans. It is essential to help the student establish a support system that will continue after graduation. During this time of tremendous change, funded services for these students often cease to exist, and their support system is pulled away from them and their families. Without a transition plan in place, they are left to handle the stresses of life after high school on their own. But with a transition plan operational since age 16 or 14, students and their families are better prepared to exit from special education and join the community as potentially productive citizens.

## Organization and Delivery of Services

A variety of specialized instructional, related services, and placement options is usually involved in order to adequately address the complexity and severity of educational and developmental needs presented by the SED population. These students and their families customarily come into contact with a multiplicity of professionals and agencies in the course of securing educational and mental health services. There is a need to develop consistency and coordination across the numerous services provided by these various disciplines, professionals, educational programs, clinical treatments, residential components, and other related services. Collaboration is the most effective model to achieve this coordination.

### Butte County Day Treatment Program

*The Loma Vista School in Butte County offers students with serious emotional disturbances a unique program. Through a contract with the Department of Mental Health, therapeutic staff are hired as Butte County Office of Education employees and work with teachers to provide comprehensive services in the day treatment program on site.*

*The interagency partnership also includes the Department of Rehabilitation, Private Industry Council, Far Northern Regional Center, Butte College Disabled Students Services, and all of the participating local school districts in the county.*

*The program provides group, individual, and family counseling. If medication is needed, a child psychiatrist is available for consultation. It also includes components of education, socialization, and recreation. As students work their way through the program, an effort is made to integrate them back onto their local school campuses.*

Variability exists across districts in the number and range of service options available, the design of delivery systems, the local administrative policies, the coordination of services, and staff competence. It is a role of the special education local plan area (SELPA) to coordinate these services and assure the full range of options. The local plan can resolve this diversity or lack of programs through regionalization and coordination of programs. The SELPA can often save repetitious contacts with community agencies and services by acting in a coordinating capacity for several districts.

## Collaboration

Effective collaboration can be infused into the daily operation of the school and involved agencies. The process incorporates a cultural sensitivity and extends into classrooms, agencies, the offices of private practitioners, and the family home. Collaboration can serve as an integral part of the relationship between family, teachers, assistants, counselors, psychologists, and administrators, etc. at the school as well as with parents, mental health professionals and other involved parties in the community. Evaluation of the effectiveness of the programing and collaboration is a result of developing and evaluating measurable and observable goals and objectives.

In order to create a positive result from this dynamic potential, the disciplines of education and mental health must be organized as a team with team goals leading to the realization of the individual educational and therapy goals of each student. A model for collaboration consists of the following components:

- Strong interagency cooperation
- Joint problem solving
- Collaborative program development
- A strong parent focus

- A continuum of care for students with serious emotional disturbances
- Cultural sensitivity in services and staff

Efforts at achieving integration of service delivery systems have included the mental health consultant and collaborative interdisciplinary team approaches. Facilitating the interaction and coordination of services can also be strengthened by using a trained case manager who will be responsible for eliminating duplication and ensuring that the services provided are following the treatment plan and meeting the needs of the student with serious emotional disturbances. This function becomes even more important as the student moves in either direction along the continuum of least to most restrictive settings. This role could be assumed by an educational psychologist, a program specialist, or possibly the parent who would accept primary responsibility for coordinating the contacts and interactions between and among the various agencies and individuals serving the student and family.

### Professional Consultation

In addition to the collaborative consultation services focused on the student and the teacher, there may be the need in some settings to provide school staff (teacher and aide) with access to psychological or psychiatric counseling supportive of their own mental health needs. The daily encounters and occasional episodic confrontations, especially in settings that do not provide opportunity to unwind with knowledgeable adults, requires that staff have the opportunity to settle their own personal feelings in consultation with a mental health professional. This should be someone known to the teachers, contracted for by the district, and available both for planned meetings and on-call in a crisis situation.

## Educational Interventions

There is disagreement among professionals whether academic skills or social/behavioral skills have greater priority. There is a belief that, "The students need to be able to stay in their seats before I can teach them anything." On the other hand, there are professionals who believe that a strong academic program relevant to the students' interests and motivational level is critical to problem behavior. There is an increasing awareness of the significance of providing students with serious emotional disturbances with educational programs that provide high quality teacher-directed instruction as part of a complete program to develop the skills required to function adequately in normal environments. Studies consistently indicate that academic underachievement is a primary characteristic of students identified with serious emotional disturbances.

Appropriately designed academic instruction ensures that students are provided with successful learning experiences and can serve as the focal point for effective intervention and treatment. In programs that develop this component, the students are provided with the opportunity to work in groups with other students and have instruction, feedback, and effective correction that is geared to their specific needs. The formal curriculum components of programs for students with serious emotional disturbances are typically assigned the largest block of time in the student's instructional day. It is important that scheduling be arranged so that academics have a high priority and are uninterrupted.

## Academic Instruction

An increasing amount of evidence has established that there are particular elements that are present in effective instruction. If teachers provide these elements, it increases the probability that the students will develop needed academic skills as a result of the instruction they receive in the class. This aspect of the program is critical for the student with serious emotional disturbances, even those who are gifted, as they typically enter the special education program with their achievement level below that of their general education class peers. It is believed that the development of appropriate academic skills will assist them in ultimately returning to the regular classroom, in perceiving themselves as capable of learning, and in reducing the frequency and intensity of relationship and behavioral control problems associated with their prior learning histories.

A number of authors have documented the elements included in the research on teacher effectiveness (e.g., Brophy & Good, 1986; Rosenshine & Stevens, 1986) and its appropriateness with students with serious emotional disturbances (e.g., Lewis & Doorlag, 1991; Morgan & Jenson, 1988; Schloss, Smith, & Schloss, 1990). The following list is comprised of components consistently found in effective instruction:

1. Maintain an academic focus
2. Hold high expectations for students
3. Specify and order objectives to promote coverage of the core curriculum
4. Use data on student performance to ensure accurate placement
5. Maintain direction and management of the classroom

### Vista Sands Children's Socialization Program

*Vista Sands Program, Imperial County Department of Mental Health Services, provides a structured early intervention activity program for all children ages 6-12 using behavior modification, education enrichment, recreation, art therapy, and case management services. The program is designed to serve behavioral and emotionally disordered children in a nontreatment setting with the close collaboration of parents and other social services. Children participate daily in highly structured activities that focus on skill acquisition and social development. Activities include exercise, arts and crafts, discussion groups, and educational field trips. A point and level system is used which provides a means for a child to gain more privileges for positive behaviors and participation. Students placed in the program are not only special education students, but all children in the school system who need such a program.*

6. Monitor progress to hold students accountable
7. Teachers select and direct the instructional materials and activities
8. Conduct instruction in groups rather than in one-to-one settings
9. Provide academic activities that assure a high percentage of correct responses
10. Provide immediate feedback and correction
11. Provide independent practice when initial competency is demonstrated
12. Organize time efficiently
13. Establish efficient administrative arrangements to increase instructional time
14. Provide a positive classroom learning environment
15. Establish cooperation rather than competition among students

These areas are important to consider when examining educational programs for students. Frequently, instruction provided in SED programs involves little or no interaction between the teacher and the student or between the student and their classmates. Too often the student's interaction is with the printed material in a folder and feedback or correction is provided long after the student completes the task (e.g., later that period or the next day) and is not associated with the original task.

## Social Skills Instruction

Special educators have been aware for some time of the importance of including social skills instruction as a regular component of the instructional program for students with serious emotional disturbances. Recently there has been an increased amount of attention in the professional literature on the use of social skills training or instruction with students with serious emotional disturbances. This is an area in which the skills of SED students are underdeveloped and one in which it is highly unlikely that they will spontaneously develop the skills necessary to function appropriately in social situations. Current evidence clearly indicates that problems in the social skills area fall into several specific categories (e.g., Gresham, 1981) and that these skills can be taught (e.g., Cartledge & Milburn, 1986; Nelson, 1988; Rinn & Markle, 1979).

Gresham (1981) reports that social skills problems fall under the following dimensions:

**Skill deficits** occur when the student has not acquired the social skill. In this case, it is best to teach the required skill through techniques that involve observational learning or modeling. It is important to consider the possibility of skill deficits because it is often assumed that students with disabilities possess comparable skills with their age peers who have readily demonstrated the skill, yet developmentally the socially/ emotionally delayed student has not kept pace in this area.

**Performance deficits** exist when the student possesses the skill but does not use the skill when it is required because of response inhibiting anxiety or low motivation. This problem is best remediated through a behavioral approach that involves manipulating antecedents and consequences of social behavior. Some experts also believe that reinforcement-based techniques are best for increasing or maintaining skills that are initially developed through modeling.

**Self-control deficits** appear when the student lacks the controls necessary to inhibit impulsive, disruptive, or aggressive social behavior. This differs from performance deficits because they perform behaviors which are inappropriate under the environmental circumstances or they perform behaviors without considering the consequences of their responses. Many cognitive behavior modification techniques are effective in modifying these deficits, such as self-control training, self-instruction, verbal mediation, relaxation, and self-reinforcement. Specific training in interpersonal problem-solving skills has also been demonstrated as having short-term and lasting effects on improving the social and behavioral skills of students with serious emotional disturbances (Spivack & Shure, 1974; Wood & Long, 1990).

The research evidence in this area indicates that, just as in academic areas, providing appropriate instruction in social skills can teach students new skills or help them to more effectively use those skills they already possess (e.g., Cartledge & Milburn, 1986; Hollinger, 1987; Nelson, 1988; Rinn & Markle, 1979). These reports have documented ways to increase the efficiency and effectiveness of the instruction in this area. This instruction is most effectively conducted when the students are in environments that consistently respond to their behaviors in a manner that encourages the use of appropriate behaviors and discourages the use of inappropriate behaviors. Social skills instruction involves the use of a variety of methods or techniques that include the following:

1. Expose the student to live, video, or film examples that model the requisite behavior. This technique is most effective if multiple models are provided rather than a single model, the model displays a broad range of behaviors, and both

appropriate and inappropriate behaviors are modeled. Evidence indicates that the effects of the model are greater when the observer perceives the model to be similar to themselves (e.g., same age, gender).

2. Use role playing or behavioral rehearsal activities to provide opportunities for the student to practice the skill. These activities increase the effect of modeling because the student rehearses the skill immediately after observing the model and this activity produces a greater improvement than modeling alone.

3. Provide positive reinforcement techniques to encourage the continuation of the skills taught and increase the chance that the appropriate skills will occur more frequently. Trainers should follow the general guidelines for increasing the frequency and effectiveness of positive reinforcement.

4. Use practice opportunities that provide coaching along with the use of prompting and encouraging to improve the student's skills. These experiences emphasize the importance of clear and detailed guidelines for the student. In addition, the immediate application of feedback such as prompts, modeling, and correction can speed the acquisition of social skills.

5. Provide training in problem-solving skills to improve deficient social skills that may result from the use of inappropriate cognitive strategies in interpersonal situations. This training typically involves teaching some specific problem-solving strategy so that the student is able to select an appropriate choice of how to deal with social situations encountered. The goal of this type of training is to provide the student with skill in using a strategy that can guide performance across a wide range of situations rather than teaching specific responses to specific situations. For example, one strategy might be to teach the student to evaluate an interpersonal situation by using a set of statements such as: (a) What was I supposed to do? (b) I need to look at all my possibilities, (c) I have to concentrate or focus in on the alternatives, (d) I need to choose one, and (e) How well did I do? This basically involves a use of the techniques of self-coaching, self-evaluation, and self-reinforcement in dealing with social situations.

6. Provide activities that increase the probability that the skills developed during the social skills training activities will generalize to other settings. Examples of procedures that promote this generalization are as follows:

- ☐ Teach social skills that can be realistically used in the student's daily interactions with others and ones that they will value as useful (i.e., it will not help to develop skills that are not age appropriate for the student or ones that are useful only in the special education setting). The teacher should encourage others around the student (e.g., other teachers, students, friends, family members) to support the student's use of the new skill.

☐ Teach the students to use a variety of responses to similar situations. Most students with serious emotional disturbances have limited response repertoires in dealing with problems, and it is important to provide practice in the use of a range of responses under various conditions through techniques such as role playing.

☐ Work toward training "loosely" under varied conditions. If very structured and scripted lessons are initially used, work toward providing students with practice in using the new skill in situations they identify and with responses stated in their own words.

☐ Train across multiple persons and settings common to the natural environment. Do not confine training to the same group and always in the same classroom setting but attempt to work toward application with the various types of people and settings that occur in "the real world." Capitalize on opportunities to train and practice in settings outside the classroom (e.g., playground, lunchroom, school bus) and to coordinate the responses of staff to the student's performance.

☐ Fade the use of more artificial training consequences (e.g., point systems) as the training progresses in order to approximate natural contingencies (e.g., successful interactions with others, praise from others). Change the schedule of reinforcement by moving from the more continuous reinforcement used as skills are being initially developed to more intermittent reinforcement as the skill is mastered.

## Social Skills Training Programs

Social skills training programs generally contain (a) a checklist or rating scale designed to assess student social skills and to identify areas in which instruction is needed, (b) guidelines for developing specific skills, (c) a recommended format for providing the instruction, and (d) activities designed to help in generalizing the skills to other settings.

The level of structure included in the programs can vary greatly. For example, social skill training programs such as the *ACCEPTS (A Curriculum for Children's Effective Peer and Teacher Skills) Social Skills Curriculum* (Walker et al., 1983) for elementary students, the *ACCESS (Adolescent Curriculum for Communication and Effective Social Skills) Program* (Walker, Todis, Holmes, & Horton, 1988) for adolescents, and *Getting Along With Others: Teaching Social Effectiveness to Students* (Jackson, Jackson, & Monroe, 1983) provide structured lessons that include scripts to be used by teachers in conducting the lessons.

Other programs such as *Skillstreaming the Adolescent* (Goldstein, Sprafkin, Gershaw, & Klein, 1980), *Skillstreaming the Elementary School Child* (McGinnis & Goldstein, 1984), *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth* (Goldstein & Glick, 1987), and *Social Skills in the Classroom* (Stephens, 1978) provide more general guidelines for teaching each skill area and for conducting the lessons.

☐ Provide students with reinforcement for the accurate self-reports of performance. This is especially important when the student does "homework assignments" that provide the opportunity to practice the skill in a new setting outside of the classroom and to accurately report their successes and problems to the teacher and possibly to their social skills training group.

☐ Help students generalize their newly developed skills by positively reinforcing them for using the skills spontaneously in appropriate applications that they identify. Encourage them to provide suggestions for new role-playing situations and practice opportunities to be used in the instructional setting.

☐ Reinforce peers and other staff for interacting with the target student and for encouraging the use of new social skills when they are appropriately participating in activities.

☐ Consistently program generalization activities into lesson plans rather than hoping for them to occur naturally.

☐ Involve parents, support services, and resource personnel in training to prompt, rehearse, and reinforce skills throughout the child's day.

There are currently a number of commercially available social skills training programs that have been developed and researched, and there are new programs constantly being created. These programs frequently contain many of the same basic components and often have similar types of formats for developing the skills. The overriding similarity of these programs is that they consist of techniques for specifically teaching the behaviors needed by SED students, and they provide ways of assuring that the social skills developed in the classroom are practiced under controlled conditions and consistently exhibited in their lives. These programs are not limited solely to helping students function while in a special education program, but they attempt to develop the social skills that will help them function more effectively in their home, neighborhood, school, and later in their chosen jobs and adult life.

All of the previously mentioned programs are relatively inexpensive and can be implemented effectively with minimal training by professionals skilled in group instructional techniques. Many teachers and resource personnel find it most efficient to start with the more structured programs and then to use the other programs as they develop their own instructional skills in this important area.

Behavior Intervention System
Los Angeles County

*Teachers, psychologists, and administrators from the Los Angeles County Office of Education have developed a comprehensive behavior intervention system which reflects current principles and practices concerning behavior change. This system is compiled into guidelines which cover classroom organization, prevention, assessment, and principles and techniques of intervention.*

*The materials were designed for use by classroom teachers (both new and experienced) and by program administrators.*

## Behavior Management Strategies

It is the responsibility of the professional staff working with students with serious emotional disturbances to develop appropriate interventions that will increase the occurrence of appropriate behaviors, decrease the number and frequency of inappropriate behaviors, and provide instruction in appropriate behaviors that students do not have as part of their repertoire. An important component of special education programs serving students with serious emotional disturbances involves managing the inappropriate behaviors of students and providing a setting that will lead to the development of more appropriate behaviors. This is important because the behaviors of students with serious emotional disturbances are often disruptive to the organization and stability of the classroom program, and at times, dangerous to the health and safety of other students and adults. Students who continue to exhibit these behaviors will not function successfully in their school, home, or community settings.

Effective behavior management should begin by establishing specific guidelines that provide realistic expectations for student behavior, ones that are clearly communicated (and if necessary, taught) to the student. It is important that the consequences for meeting, or not meeting, these expectations are clearly stated and enforced. The strategies used should be as positively oriented and as nonintrusive to both the student and the teacher as possible. It is crucial that more attention be provided for appropriate behaviors than for behaviors that are not acceptable in the setting. As is the case with all educational and therapeutic interventions, it is necessary that decisions on the need for, and the effectiveness of, interventions are based upon data gathered from directly observing the student in the setting in which the expected behavior is to occur.

Behavior management techniques should include a range of positive, proactive intervention alternatives that could be employed within the regular or special education classroom prior to exercising more intrusive and negative techniques such as removal from the classroom or other forms of control. Examples of effective behavior management techniques are as follows:

1. Teachers should always attempt to introduce a positive behavior management system within the classroom that involves the use of positive events such as praise, tokens, points, or level systems with all students as a means of teaching and positively reinforcing the use of appropriate behaviors and behavioral self-control.

2. By creating areas such as study carrels or full-size cubicles within the classroom, a place can be created that can be used for a limited time to reduce the classroom stimulation and provide the student with an opportunity to regain self-control.

3. It often helps to manage behavior by adding staff or volunteer resources. Behavior is often improved with the provision of increased adult contact, coaching, supervision, or an escort throughout the day. A schedule for fading, and the eventual elimination of this support, should be established as behavioral gains are accomplished.

4. When students exhibit particular behavioral problems, it is appropriate to develop an individualized behavioral plan that targets the problem behavior(s) and provides for a specific intervention that will be initiated and changed or adapted based on its effectiveness and the needs of the student. Such plans can be written to extend across other settings at school, at home, during transition times, and to provide continuity throughout the school day.

5. It can be helpful to institute a "conference" between the student and the classroom teacher at some point after an incident occurs to participate in activities such as joint problem solving or behavioral contracting. These activities should be directed at ways of developing the student's skills in behavioral self-control and should avoid simply providing attention to students who exhibit inappropriate behaviors.

6. It is often helpful to provide consultation to the classroom teacher to assist in collectively achieving a broader understanding of the factors that may contribute to the disruptive behavior and lead to the development of more effective approaches to resolve the problem before it reoccurs.

When inappropriate behaviors do occur, often educators, school officials, and lay persons respond by removing the student from the classroom or other setting in which the behavior occurred. This may occur more frequently with students with serious emotional disturbances than with other special education categories because of the types of behaviors they exhibit. While removal may accomplish positive functions such as containment of the disruptive behavior, protection of the welfare of other individuals, assuring continuity of the classroom program, providing a more appropriate learning environment for other students, etc., removal can also produce a variety of undesirable outcomes. Removal can contribute to conditions that create ethical questions regarding the student's continued access to the educational setting and make it difficult to honor the basic principles of LRE. For example, continued removal from the setting can contribute to (a) difficulty in reintegrating the isolated student back into the classroom; (b) engendering feelings and perceptions of rejection; (c) incidental reinforcement of disruptive behaviors as a means to avoid classroom and academic demands; (d) failure to generalize behavioral control acquired or provided in the special setting to the classroom where the problem behavior first occurred; (e) increasing time out of the classroom with increasing frequency of infractions, with associated loss of relationship to the teacher and classmates, lessened academic instruction, etc.; and most importantly, (f) decreasing the need for the teacher (or other responsible adult) to develop an appropriate intervention strategy to develop appropriate student behaviors. In this regard, all possible positive strategies should be used before removal is considered. If removal is used, it is important to include clear, identified means and mechanisms that provide for, and ensure, the reintegration of students with serious emotional disturbances to the classroom as quickly as possible. When the need to remove the student from the classroom continues, it is time to convene the IEP team for reconsideration of placement and appropriate services.

## Program Evaluation

Evaluating programs for students with serious emotional disturbances is an objective that generates a great deal of interest among special educators and treatment personnel, but one that typically receives little professional attention in most school or treatment settings.

Determining what intervention programs (or parts of programs) or service delivery systems make a difference in positively influencing the growth and development of students is critical to anyone in school or treatment settings. Given the increasing complexity of educating today's SED youth, it is always important to establish empirical measures designed to validate the instructional and treatment philosophies, methods, and materials used in a program. At the same time, efforts to systematically quantify variables of such universal interest as student outcomes related to key treatment variables presented over time are hampered by such obstacles as the lack of consensus on the definition of SED, heterogeneity of the SED population, lack of agreement on the key characteristics of effective teachers and teaching techniques, multidimensional nature of programs, lack of agreement on which are the meaningful outcome variables, and the limitations of measurement procedures and research designs.

One way to address this issue at a general level is to encourage special educators to adopt a working philosophy that values evaluation of all aspects of their interactions with individuals with serious emotional disturbances. This inquiring attitude helps to maintain a focus on the relevant dimensions of one's work and helps to ensure attention to the level of quality standards established for the program. Perhaps an even greater need for an evaluative stance exists with programs serving students with serious emotional disturbances, given the limited knowledge of what practices work most effectively with this increasingly complex student population. There is greater responsibility on SED professionals to be asking themselves the critical questions regarding the evaluation of current practices, in the absence of organized advocacy groups on behalf of children with serious emotional disturbances, particularly those who are no longer served at their neighborhood public school.

## Factors in Evaluating Program Quality

Another way to address the issue of program evaluation is to identify those dimensions of service delivery systems that have received the recognition of respected professionals as being associated with program quality and effectiveness. In the current climate of attention to this issue, there are published reports of quality indicators of effective schools such as *The Bank Street Report* (Knitzer, Steinberg, & Fleish, 1990) or the *1988-89 Criteria for Selection of Special Education Exemplary Programs* (Winget & Kirk, 1989). These reports have identified a partial listing of program variables to be considered in evaluating program quality. This list includes (but is not restricted to) the following:

1. Adequacy of personnel preparation prior to entering the educational and clinical treatment setting and opportunities for continued professional growth.
2. Availability of special instructional materials designed specifically for use with students with serious emotional disturbances and adapted for the unique needs of individual students and small groups.
3. Presence of core curriculum and academic instruction that address the specific academic deficits of the student with serious emotional disturbances and are integrated with the attention given to social and behavioral deficits.
4. Presence of ongoing support for classroom teachers in the form of resource personnel and consultation services.
5. Participation of parents in the planning of their child's educational and treatment program and a provision for providing the parent with support in acquiring appropriate services and training when needed.

6. Availability of designated instruction and services and other related services that follow the child to support student growth and transition.

7. Presence of carefully planned efforts to transition students in both directions along the LRE continuum according to their individual needs at any given point in time.

8. Adequacy of the physical plant and environmental conditions to support self-esteem and staff morale.

9. Examination of student outcomes including: Where are students now? Has their academic achievement improved? Are their social interactions more appropriate?

10. The degree of collaboration achieved with community service providers and how well they serve the student.

## SECTION 4

# COMMUNITY SERVICES TO AUGMENT PUBLIC SCHOOL SERVICE OPTIONS

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# COMMUNITY SERVICES TO AUGMENT PUBLIC SCHOOL SERVICE OPTIONS

## The Need for Collaboration of Public Education with Other Services

School personnel have traditionally attempted to address academic and classroom behavioral problems within the context of the school environment. But, when schools cannot handle the complexity and intensity of needs demonstrated by students with serious emotional disturbances, an expanded IEP team is convened. This expanded team utilizes the expertise of mental health professionals drawing together appropriate resources and support services from the community to effectively meet the educational and developmental needs of students with serious emotional disturbances and their families.

These needs are typically so dynamic and multifaceted that other professional perspectives and disciplines need to be involved. Families with children with serious emotional disturbances often need support services of varying degrees of intensity and scope throughout the child's developmental years. Many children and families become a shared responsibility of a variety of individuals and social institutions, requiring a coherent approach to satisfy the child and family's special needs.

The range, scope, and integration of these services are complicated and often require extraordinary case management efforts, as well as a spirit of flexibility and cooperation across all agencies. This chapter describes these services and indications for their use and some of the issues involved in bringing services together in an efficient and effective manner.

## A Shared Vision for Community-Based Services

One of the most significant developments of the past four years is the effort of school districts and mental health agencies to serve youth with serious emotional disturbances on school campuses and in the community. Throughout California, school districts and mental health agencies are developing partnerships in which mental health services, both outpatient and day treatment, can be provided on school campuses minimizing the disruption of the educational program for the student with serious emotional disturbances and maximizing the potential for true collaboration and coordination among mental health and educational professionals. The sharing of resources, the daily interactions among educational and mental health staff, and the mutual support and understanding benefit students with serious emotional disturbances and their families. Location of services on both public and private school campuses is strongly encouraged throughout California as it underscores the efficacy of interagency cooperation to significantly and directly impact the lives of the community's more seriously disturbed children and adolescents and the people with whom they interact with on a daily basis.

## National Mental Health Initiative

The national movement to provide integrated, community-based services for seriously disturbed youth has begun to be replicated throughout California. In 1988-89, the National Institute of Mental Health (NIMH) awarded California a three-year grant for a Child and Adolescent Services System Program (CASSP) to improve the service delivery system for children and adolescents with serious emotional disturbances. The California CASSP project promotes the development of an integrated, coordinated system of care among public agencies; encourages interagency planning; and promotes a child-centered, family-focused, and culturally competent continuum of services, responsive to the needs of all ethnic minority populations in California. CASSP supports the development of comprehensive data collection systems that allow for accurate assessment of children's needs. A critical element of the CASSP program has been the development of a parent network to meet the needs of the CASSP target population.

## California Mental Health Initiative

The California Department of Mental Health initiative titled "System of Care for Seriously Disturbed Children and Youth" seeks to organize and coordinate services to children who have serious emotional disturbances and who receive multiple services in a variety of public agencies. The System of Care for Children and Youth ensures that the least restrictive and most appropriate services are provided for children and youth in family homes, schools, juvenile halls, and residential, foster, and group homes. The System of Care has a strong focus on the educational life of the target population with community mental health providing a system of case management services. This initiative had its impetus with the Ventura County Demonstration project at Phoenix School and has expanded to four other counties: Santa Cruz, San Francisco, Riverside, and San Mateo.

Central to the system of care are two core values. First, the system of care must be child and family centered. The child and family are focal points of this system and determine the types of services needed. This focus requires a commitment to adapt services to the child and family rather than expecting the child and family to conform to preexisting services configurations. Secondly, the system of care must be community-based. Community-based programs provide less restrictive, more natural environments. While institutional care may be indicated for certain children at various times, in many cases appropriate services can be provided in less restrictive settings within or close to the child's home community.

**California is the first state to implement legislation which defines interagency responsibilities for providing services to children with handicaps.**

System of Care services include comprehensive case management services to all children with serious emotional disturbances across all systems: development of interagency networks, development of programs to decrease the need for out-of-home placements (including provision of services in school, juvenile justice facilities, home, or other environment); and provision of staff training across agencies.

## California Legislation Defining Interagency Responsibilities

California is the first state to implement legislation which defines interagency responsibilities for providing services to children with handicaps. Under Chapter 26.5 (A.B. 3632, Ch. 1747, Statutes of 1984), educational and mental health resources are combined in an interagency delivery model. This legislation makes local mental health programs responsible for providing mental health services to special education students who need such treatment to continue their education.

While such treatment may include out-of-home residential services, recent legislation in California strongly support the provision of services to preserve the integrity and quality of family life and to avoid the costly and traumatic separation of children and youth through residential placements. Family preservation services are offered to families with a child who is facing imminent removal from the home. These intensive interventions are provided in the home or school environment and are critical to the successful treatment of youth with serious emotional disturbances. Family preservation services may prevent the need for future expensive institutional care.

Local interagency agreements and current regulations (P.L. 94-142 as amended by P.L. 101- 476 and Chapter 26.5, Government Code) charge the expanded IEP team with identifying all possible alternatives to out-of-home placement. Such alternatives may include any combination of cooperatively developed education and mental health service options. Additionally, the 1990 Individuals with Disabilities Education Act (P.L. 101- 476) encourages demonstration projects which develop and apply strategies and approaches to reduce the use of out-of-community residential programs and the increased use of school district-based programs (which may include day treatment programs, after-school programs, and summer programs.)

## Service Coordination Involves Interdisciplinary Training

To effectively coordinate services between special education and mental health, interdisciplinary training on laws, regulations, and procedures is critical for professionals. When different agencies are involved in providing services and programs for children and their families, there is a potential for problems to occur if the expanded IEP team (educational plus mental health professionals) is not aware of these differences in law. Below are some areas in which regulations differ between agencies.

### Confidentiality

Relevant, timely communication between school personnel and mental health personnel is essential to help students with serious emotional disturbances and their families achieve the goals and objectives of the IEP. Due to differing laws and regulations governing educational and mental health agencies regarding the release of confidential student/patient information, it is necessary to obtain parent authorization to release specific, relevant information to each agency. The expanded IEP team should be judicious in their discussions about the student and keep all information within the parameters of the IEP. Information about family members or the past history of the child may not be directly relevant to instruction in the classroom although it may be critical to mental health treatment. The only exception to this rule is in the event of suspected child abuse or neglect. It is important for all professionals to understand the Child Abuse Reporting Law and their responsibility for reporting any instances of child abuse pursuant to Penal Code 11165 et al. and the Welfare and Institutions Code 307.5.

### Consent for Treatment

Consent for treatment is another issue of differing laws and regulations across agencies. It is important for school staff to remember that the special education student who receives related mental health services is also a patient at a mental health clinic and protected by patients' rights. Chapter 26.5 services cannot be provided to special education students without the consent of the parents or guardians. The mental health consent forms that parents or guardians sign are separate from those of education and will designate the parameters for release of information and consent for mental health treatment.

The IEP team typically works with the family to understand their needs and concerns. This is also true with recommended mental health services. Parents and children who understand the importance of related services will be more cooperative in following through with referral to such services and in exercising the

opportunity provided. Nevertheless, consensus is not always possible at an IEP meeting. Information should be made available to the parent regarding the due process appeals of IEP decisions. The education community has years of experience with the hearing process set up by the Individuals with Disabilities Education Act, but local mental health agencies historically have not had he same due process opportunities, such as mediation and hearings, that the IEP process mandates when there is disagreement. The due process safeguards are noted in current Ch. 26.5 regulations. It is necessary for all professionals to participate in this process when there are concerns about mental health services.

## Mental Health Program Services

Local mental health departments offer a range of community-based outpatient and day treatment services at public clinics or through private service providers that are expressly designed to meet the needs of youth. In addition to the obvious goal of helping students with serious emotional disturbances be successful in educational programs, great emphasis is placed in family preservation and successful adaptation to the daily demands within their own home and community.

Quality mental health programs can work effectively with educational professionals in addressing the intense and complex needs of students with serious emotional disturbances. These mental health programs are generally located on site at the local public or nonpublic school campus. There is active coordination and collaboration with the classroom teacher, school psychologist, and other school personnel. The parent is actively involved in the treatment process, not as a patient, but as a treatment partner. There are clear, measurable treatment goals and objectives specific to problems that interfere with the student's education and outcome criteria for evaluation purposes. Mental health services are linguistically and culturally appropriate. Scheduling of treatment services is flexible enough to meet the needs of the client and family yet still maintain treatment integrity.

Although many counties boast excellent mental health programs such as those described above, some counties lack components of the full

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continuum of care. Diminishing resources impact geographic accessibility to services, adequate resources for non-English speaking clients, transportation to and from necessary services, waiting lists, and the provision of less intense, cost-effective services.

In an effective outpatient mental health program the range of services should include the following:

### Assessment

Assessment is a multidisciplinary diagnostic service designed to provide a formal documented evaluation of the nature, scope, and possible cause of the child's need for special education and/or related mental health services. Assessment services provide the parent and the IEP team with a treatment plan that includes specific goals, objectives, frequency, and duration of mental health services designed to augment the child's educational program.

Assessment procedures include observation of the pupil in the school environment; face-to-face clinical interviews with the pupil, parents, and other significant family members; consultation and collaboration with teachers, school psychologists, private therapists, physicians, probation officers, and agency representatives; and a review of relevant education, medical, and psychiatric records. Formal psychological testing is sometimes conducted, if such testing has not already been completed by the school psychologist or a private psychologist, in order to clarify diagnoses and to enhance treatment planning in complex cases.

### Individual Therapy

Individual therapy sessions provide psychiatric, psychological, or social/emotional intervention to help children and youth raise self-awareness and understanding, learn problem-solving skills, develop insight, and change behaviors. Services are provided by licensed, registered, or waivered professional social workers, MFCCs, nurses, psychologists, or psychiatrists. Interns, under the supervision of licensed professionals, also provide services for students with serious emotional disturbances.

The technique and style of the individual therapy intervention is variable among mental health professionals according to their education, training, and experience. However, the most important considerations are the problems, needs, and developmental levels of the child. For example, nondirective "play therapy" is often used in treatment of nonverbal or preverbal, young children. Latency age children and young adolescents may be treated in a more directive, structured treatment intervention. Some older adolescents, with more developed cognitive and verbal abilities, may be able to utilize some insight-oriented, traditional "talk" therapy as the most appropriate method.

### Kings View-Humboldt Mental Health's School-Based Childrens Services Program

*This program was designed to provide therapeutic services to high risk rural youth with severe behavioral or emotional problems.*

*The program includes an Intensive Day Treatment component and a school-based Outpatient therapy component (prevention, early intervention/crisis) at 13 elementary, middle, and secondary schools in Humboldt County. Services such as school staff consultation, interagency liaisoning functions, individual/group/family therapy, and crisis assessments with consultations from the program psychiatrist and psychologist are provided at the 13 schools. Sites include all court schools, high-risk sites such as continuation high schools, and regular high schools (where significant crises such as suicide are more likely to occur). These free school-site-based services are provided to low income and high risk youth who, otherwise, would not have access to mental health services due to factors such as cost, lack of transportation, or family dysfunction. As these services include a large prevention component, many children receive services prior to the onset of a mental disorder.*

### Family Therapy

Family therapy utilizes the natural grouping of family members as the agent of change for the student with serious emotional disturbances who manifests emotional and behavioral problems. Coordination of therapeutic interventions at home as well as in school is essential to successful outcomes.

Family therapy can be one of the most powerful and effective methods of treatment for SED children in that all family members, not just the "identified parent" participate in the identification and resolution of dysfunctional patterns of communication within the family. The therapist is able to help the family learn new ways to resolve conflict; express thoughts and feelings more clearly, and practice some of the new behaviors within the family therapy sessions.

### Group Therapy

Group therapy provides goal-directed, face-to-face therapeutic intervention with the student and other clients who are treated at the same time and focuses on the mental health needs of all group members. Clients help each other with problems and have opportunities to try new behaviors for resolving conflicts and concerns under the guidance of the mental health professional.

As in the case of individual therapy, the technique and style of group therapy is variable among professionals and depends upon the needs and abilities of the client. The size and composition of the group is carefully determined by the therapist in order to develop a therapeutic environment for successful outcomes. For example, young children may be seen in small groups of only three or four members, while adolescents groups may include six to eight members. Group composition may be homogeneous (i.e., only males, only 14-year-olds, only those whose problems are identified as social isolation), or heterogeneous (males and females, ages ranging from 13 to 16, and demonstrating a variety of problem behaviors). Some children may benefit from activity-oriented groups in which a task or project that requires teamwork and cooperation is the primary method of group interaction. Older adolescents may be able to utilize a process-oriented group in which verbal interaction among group members and the therapist is the method of treatment.

### Psychiatric Evaluation and Medications

Psychiatric evaluation and medications are provided in outpatient programs. All mental health services are provided under the direction of a physician. Those clients who may require psychopharmacology to reduce anxiety, depression, hyperactivity, or psychosis are provided medical supervision by the staff psychiatrist.

The decision to use medications is determined mutually by the physician, the parent, and the student and requires frequent consultation, collaboration, and monitoring to ensure its effectiveness. The observations and reports of school staff are often essential to the physician and parents in identifying problems in the medication regimen. There are occasions in which medications may need to be administered during the school day. Clearly, it is important that there is regular, active communication between home and school regarding the use of psychopharmacology.

### Crisis Intervention

Crisis intervention is an immediate therapeutic response with a client exhibiting acute emotional distress, behavioral excess, or psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the client or others "and may result in acute psychiatric hospitalization, out-of-home placement, or intervention by the law enforcement." Crisis Intervention Services may not always be available on school sites, but provisions are made for such services in the community, including after hours and weekends if necessary. It is always important that parents and school personnel are aware of the location of Crisis Intervention Services in the community and have a plan of action to access them when needed.

### Parent Education Classes

Parent education classes are designed to teach parenting skills, help establish realistic parental expectations, facilitate parent support of one another, and provide information about child development and strategies for behavioral interventions in the home.

### Case Management

Case management services are required when a child is recommended for residential placement; however, such services may be provided to any child and family when warranted. The purpose of case management is to facilitate participation by the client and family in the recommended treatment services, to provide advocacy and consultation, and to coordinate provision of services with local school districts and other public agencies. Case management is child-focused and family-oriented, committed to long-term planning for age appropriate independence, and works to maximize the natural supports existing in the community. Case management is particularly useful in dealing with treatment resistant clients and multi-problem families who utilize the services of many public agencies such as probation, child welfare, health services, regional centers, and private practitioners.

### Washington School Day Treatment Project

*The Washington School Day Treatment Project is operated jointly by Pasadena Unified School District and Pacific Clinic, a private, nonprofit community mental health center contracted with Los Angeles County Department of Mental Health. The program serves 32 adolescents from 9 a.m. to 2 p.m. Pasadena USD has arranged to allow the educational staff to be available each morning at 8 a.m. for team meetings in which to plan for the coming day and review of the prior day's program. The staff is carefully screened to reflect a multiethnic experience and/or background, and ongoing inservice training is provided to enhance the cultural competence of the combined staffs.*

### Day Treatment

Day treatment services provide the most intensive treatment programs to children with serious emotional disturbances and youth in the community, excluding residential placement. By definition, all day treatment programs include a therapeutic milieu and must provide crisis intervention, assessment, medication services, and individual, group, and family therapies. There are two types of day treatment programs: Intensive, which requires a minimum of 208 days per year with intensive staffing and Habilitative, which requires a minimum of 125 days per year and less intensive staffing. All day treatment programs require a minimum of 3 hours per day of therapeutic activities.

Day treatment programs typically serve youth with serious emotional disturbances who have demonstrated an inability to benefit from the less structured, less intensive, outpatient services and who require specialized environments. Many participants in day treatment are transitioning back into the family and community from hospital and 24-hour residential care facilities. The goals of day treatment are to ameliorate severe symptoms to avoid the need for hospitalization or residential placement; to observe and evaluate severe symptoms, behavior, and family interaction patterns; to monitor symptoms and behaviors, especially those which are potentially destructive to self, others, and property; and to enhance the process of teaching and reinforcing age appropriate skills for self-management, problem solving, and functioning at home, in school, and in the community.

Day treatment programs are highly structured with appropriately high ratios of staff to clients and intensive, multidisciplinary services. Many day treatment programs are located in hospitals, residential care facilities, and on nonpublic school campuses. Some of the better examples of day treatment programs, however, are located on public school campuses integrated with special classes or as after-school free standing day treatment programs. These integrated programs need to be replicated and provided more readily in all California communities.

## Where Mental Health and Educational Interventions Meet: Nonpublic Schools

Nonpublic, nonsectarian schools (NPS), certified by the California Department of Education to provide special education and related service to eligible special education students, play a unique role in serving children "for whom there are no other appropriate public education programs available." Under current state law and regulation, the role of state-certified nonpublic school programs are specified and implemented through contracts with a local education agency.

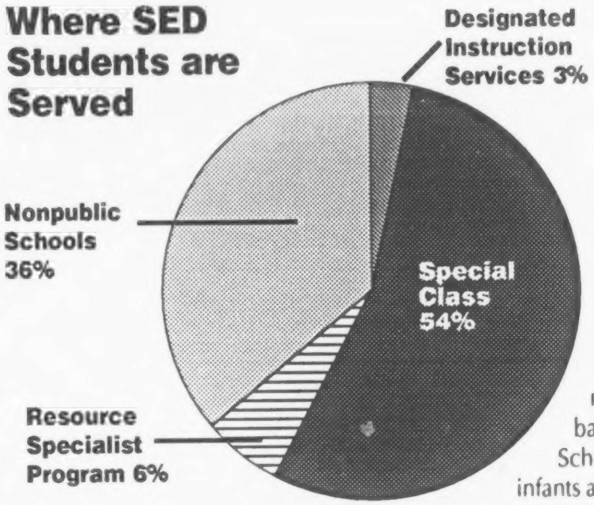
The California Department of Education certifies and monitors nonpublic day and residential schools. Local education agencies contracting with a NPS require evidence of current certification as a prerequisite for placement.

In the 1989-90 school year, the California Department of Education, Special Education Division, certified approximately 249 nonpublic school programs within and outside the state of California to provide appropriate special education and related service to eligible students. On Dec. 1, 1990, a total of 12,515 exceptional students were identified as having a serious emotional disturbance. Of that total, 4,521 students with serious emotional disturbances (representing approximately 36 percent) were placed in nonpublic, nonsectarian schools. Students with serious emotional disturbances comprise about 68 percent of the total number of students in nonpublic school programs.

On October 1, 1989, approximately 34 percent of all nonpublic school placements are those in nonpublic schools located on the site of Licensed Children's Institutions. The remaining students, 65 percent, were placed in nonpublic day school programs.

### Scope of Nonpublic School Programs

Nonpublic schools provide a complex array of programs and services which complement the unique needs of special education students enrolled in their programs. The scope and specific kind of services provided will vary across programs in the state and will determine the particular school's capacity to meet IEP team's determination of appropriate services required by each student. Program quality also varies across programs, suggesting the need to encourage program evaluation efforts and for monitoring at the state and local level.


**Where SED Students are Served**

*(Data taken from Dec. 1, 1990 Pupil Count, California Department of Education, Special Education Division)*

Consistent with state and federal law, and regulations of program options available to appropriately serve special education students, NPS programs range from free-standing day schools to schools with a day or residential treatment component to schools contained within a larger community-based residential program or hospital facility. Some, but not all, nonpublic schools serving students with serious emotional disturbances have an on-site mental health day treatment component. Schools may vary in specialization for (1) age groups served (e.g., infants and preschoolers at risk, elementary or high school students only, or the full age range including transitional community living and vocational skill training for young adults); (2) handicapping conditions (learning handicap, behavior disorder, dual diagnosis such as developmentally disabled, seriously emotionally disturbed, and multiply handicapped); and (3) levels of cognitive, academic, and adaptive functioning. Some private special education schools provide alternative placements for youngsters with special developmental needs who are not eligible for special education programs. Others combine general and special education students on the same campus with the goal of integrating special education students into general education classes.

A substantial number of residential nonpublic, nonsectarian school programs serve children and youth who are wards or dependents of a juvenile court and placed in the residential component of the program through either a county department of probation or county department of welfare. As required by health and safety laws and regulations governing such programs and service, these residential programs are responsible to coordinate the residential care or treatment needs of these children with their respective educational needs.

A private school or individual licensed professional may also function as a state certified nonpublic "agency" providing a range of related services designated on a child's IEP.

In addition to the program characteristics shared by full-day placement in public and nonpublic special schools outlined in Section 3 (p.51), other unique features of NPS placement include:

- specialized and timely assessments
- community placement with intensive service and on-site specialized resources and learning environments as an alternative to residential treatment
- integration of education, DIS, and mental health services to provide a psychoeducational, therapeutic milieu

- close collaboration with other service agencies and individuals involved with the pupil or his/her family: e.g., Mental Health, Regional Center, Department of Social Services (DSS), local law enforcement, school transportation vendors and bus drivers, probation officers, pediatricians, psychiatrists, neurologists, and other health professionals
- vocational education, rehabilitation and adult transition services including vocational assessment, community integration, supported work, etc.
- dual enrollment between NPS and public school programs with consultation to public schools to facilitate successful reintegration and mainstreaming and supervision in public school intramural activities to further enable a pupil's reentry
- higher tolerance of more intensive student behavior problems
- more intensive planning and supervision of student behavior management
- integrated extended school year programming with regular year program
- regular and frequent communication with the pupil's home environment whether it includes pupil's parent(s) home or other consenting adults, e.g., foster home, group home, conservator
- class instructional size and composition based on the needs of all individual pupils enrolled in the nonpublic school

In addition, NPS services that may be provided beyond the school day include case management, parent/family service or support, in home behavior management, before and after school child care service, therapeutic recreation, and specialized day camp programs.

When an IEP team considers placement of special education students in nonpublic schools, the responsible local education agency begins contract discussions with the appropriate NPS program(s). These procedures are discussed briefly as follows.

## Contracting for Nonpublic School Service

Section 56365 and 56366 of the California Education Code contain requirements which specify that education and related services by nonpublic schools and agencies shall be available under contract to the pupil's district, special education local plan area (SELPA), county office of education, and parents when public school alternatives have been exhausted. Additional requirements and procedures relating to contracting are contained in the California Code of Regulations, Title 5, Article 6 (commencing with Section 3061) relating to nonpublic,

**Dubnoff Center**

*The Dubnoff Center was founded in 1948 by Belle Dubnoff, who created a classroom in her home for a handful of children labeled "unteachable" and "unreachable." The Dubnoff philosophy is based on the principle that individuals with a wide range of developmental delays, difficulties, and disabilities can grow and develop positively in an integrated therapeutic educational setting. The student population ranges from age 3 to 21. An individualized education plan is created for each student with parent involvement paying a primary role in the plan's implementation. The pupil-adult ratio varies from 1-to-1 to 6-to-1, depending on individual need, in a flexible, non-graded specialized educational, clinically appropriate, and personalized treatment setting. Licensed and credentialed interdisciplinary staff work collaboratively with the child's parents and public agencies to provide the degree of structure needed to foster self-direction and independence.*

nonsectarian schools and agency services. These sections also specify that NPS schools and agencies must be certified by the California Department of Education. See also the *Handbook for Contracting with Nonpublic Schools for Exceptional Individuals* (1990), California Department of Education, for more detailed information.

When contracting with nonpublic schools, the local education agency must ensure that services provided are consistent with each pupil's written IEP and that the progress of the student is monitored by the district or SELPA.

In most instances, a Master Contract Agreement is executed by the local education agency (LEA) with the NPS which contains general provisions, procedures, and program oversight requirements for the LEA use of NPS service, including their basic costs. As students are considered by the LEA for placement, an Individual Service Agreement or contract is executed with the NPS which specifies the particular special education and related service required for each student.

## State Funding for LEA

When the NPS contract is executed with the pupil's district or SELPA of residence, the average daily attendance for that student is not generated. Depending upon the agreements in the written special education local plan area, the district (or SELPA) receives a 70 percent state reimbursement of the excess costs of the NPS tuition to provide educational services. However, when the NPS contract is executed with the county office of education in which an licensed children's institution (LCI) is located, the county office receives a 100 percent reimbursement of the excess costs of the NPS tuition.

Chapter 26.5 of the California Government Code assigns interagency responsibility and authority for the provision of education and mental health services to meet the needs of SED children and youth. Chapter 26.5 also contains the legal basis for local public health and mental health agencies to contract with state certified nonpublic schools and agencies to provide related mental health and residential service to special education students.

In meeting the challenge of serving the community's most difficult and demanding children and their families, many nonpublic schools and agencies actively engage the interagency collaboration of other public and private community service agencies and professionals. Depending on their meeting standards for licensing, certification, or vendorization, the NPS becomes eligible for additional sources of funding, thereby maximizing education dollars and enabling them to provide a broader, more intensified and enriched service program. In this way the NPS, like the public school, considers itself a community school, centralizing and coordinating the multiple services necessary to meet the often complex need of today's SED population.

These funding sources include:

- Short-Doyle and Short-Doyle Medi-Cal contracts which include such services as intensive or habilitative day treatment; outpatient day counseling; mental health support services to designated developmentally disabled, dual diagnosed, and autistic individuals and collaboration and case management with parents and other involved agencies and professionals
- Regional Center contracts which include such services as out-of-home residential care, in-home behavior management services, targeted case management services, after school recreation, special day camp during school vacation periods etc.
- County Department of Health, Children's Services which include medical and other health care services that are medically necessary for special education students
- County Department of Social Services and Probation Services for 24-hour out-of-home, residential care and supervision of special education students who are dependents of the juvenile court
- Private donations and community-based funding support, e.g., foundation and private sector businesses, which enable nonpublic schools to either fund the education and related service needs of non-eligible special education students or enhance services provided to eligible students

**Peninsula Children's Center**

*Peninsula Children's center is an integrated mental health and special education program for students ages 2.5-22 years who are unable to attend regular schools because of their need for intense therapeutic services. Students may have learning, speech and language, and/or developmental deficits, along with severe behavioral and emotional problems which necessitate more individual attention and more intensive services than that provided in the public schools. Many early adolescents exhibit predelinquent or antisocial behavior; many have suffered physical and sexual abuse.*

*Treatment is provided by multidisciplinary teams consisting of special education teacher, program counselors, speech pathologist, vocational coordinator, caseworker (a mental health professional); and the consulting psychiatrist. Students able to benefit from counseling are seen individually or in small groups. Counseling is available for individual family members, the couple, or the family unit. Support groups are held periodically for parents and siblings. Comprehensive treatment reviews, including outside mental health and special education consultants, are held for an intensive evaluation of each child's progress. Each child is reviewed 3 times per year.*

## Out-of-Home Services and Programs

Placement in an educational environment other than a regular education class in the student's own neighborhood should be considered only when the expanded IEP team determines that the regular environments, services, or curriculum cannot be modified effectively to meet the student's needs as specified in the IEP. Consistent with the determination of an expanded IEP team, a student with serious emotional disturbances may be placed out-of-home in one of a variety of residential treatment settings in order to continue education services. This is considered an "educational" placement. However, when a student with serious emotional disturbances is placed in a psychiatric facility for emotional or behavioral problems of an acute nature (described below), the placement is not an educational one and is therefore not an IEP team decision. It is a medical or psychiatric decision and consequently not funded by education.

There are five basic types of out-of-home programs: (1) state diagnostic centers, (2) residential programs, (3) community-based hospitals, (4) state hospitals and developmental centers, and (5) the juvenile justice system. These settings are not usually considered part of the range of public school special education services, but come into play when the problems of a particular student with behavioral or emotional disorders are so serious, pervasive, or complex that the child cannot be safely or effectively maintained in existing public or private school settings in the community, even with supportive mental health services.

As noted above, eligibility for out-of-home care is not solely an educational decision. Although the school identifies the student as SED according to federal educational guidelines, it is necessary for local mental health agencies to assess

the student to determine the need for mental health services, including the need for residential treatment. This is accomplished in the expanded IEP process. When a student with serious emotional disturbances is in need of out-of-home placement in a residential program in order to benefit from his education, the residential living cost is paid through a process of mental health authorization for board and care paid by county welfare, which is then reimbursed by the Department of Social Services. The child's local school district pays only the educational costs.

When a child with serious emotional disturbances is in need of acute care in a psychiatric hospital, the hospital costs are not paid for via Chapter 26.5 since the child is placed for medical reasons (i.e., treatment of emotional/behavioral problems) and not for educational reasons. Costs are the responsibility of family or other sources of income. However, the child's local school district may still be responsible for the educational services provided in the hospital setting.

In selecting an out-of-home placement which is *appropriate* for the student, the following variables should be considered:

- Scope and specificity of active programming
- Geographical distance to the child's family
- Staffing ratio, program structure
- Access to nonhandicapped students
- Access and integration into general education

## Types of Programs

Each of the programs described below may have school programs within their settings or may utilize nearby private or public school facilities. In many cases, public school funds are used to fund teaching staff within psychiatric settings either through county school programs or state certified nonpublic schools on hospital sites. Other psychiatric hospitals may offer only the equivalent of home-bound or hospital teaching for a few hours per week.

The out-of-home programs in this section are arranged as follows:

**State Diagnostic Centers**

**Residential Programs**

- Therapeutic foster care homes
- Specialized group homes
- Residential NPS programs
- Residential treatment centers

**Community-Based Hospitals**

- Private psychiatric hospitals and medical hospitals with psychiatric units
- Private psychiatric hospitals with a County Department of Mental Health Medi-Cal/Short-Doyle Contract
- University psychiatric hospitals
- County hospitals with psychiatric units

**State Hospitals and Developmental Centers**

- Operated by the California Department of Developmental Services or California Department of Mental Health or California Department of Social Services

**Juvenile Justice System**

- California Youth Authority (CYA) Programs

***The AB 3632 funding mechanism is not an avenue for payment of inpatient care, since the child is hospitalized for medical reasons and not for educational reasons.***

## State Diagnostic Centers

State Diagnostic Centers provide a comprehensive individualized assessment in a residential setting for each student referred by the local educational agency. The three State Diagnostic Centers (Los Angeles, Fresno, and San Francisco) are operated through the California Department of Education. There is no cost to the family for these assessment services. Comprehensive assessments may be done either at the local school district or at a Diagnostic Center. In the latter case, the assessment is carried out within a residential setting and may last from several days to several months. The complexity of the presenting problems and the referral questions determines the intensity and length of the assessment services.

Diagnostic Centers also develop detailed instructional strategies, behavioral interventions, and other recommendations for the district to use in serving the student in their local program. Parent education and support programs are an integral part of the services provided. In addition, the Diagnostic Centers provide local educational agencies with field-based consultation, technical assistance, and various inservice training programs.

## Residential Programs

Residential Programs include therapeutic foster homes, specialized group homes, residential nonpublic school programs, and the more structured residential treatment centers. An approved residential program is called by different names depending upon which agency is involved with placement. An approved program may be called a "group home," a licensed community care facility, a licensed children's institution (LCI), or an intermediate care facility (ICF), but is licensed by the Department of Social Services, Community Care Licensing (DSS/CCL) Division or by Health Facilities Division of the Department of Health.

Therapeutic foster care homes provide a "family unit" type of living environment for the child. In addition, the foster parents are trained in crisis management and behavior modification. The foster parent provides access to psychotherapy, social work services, and other resources located in the community. The child attends the local public or private school. Therapeutic foster care homes are regulated through the Department of Social Services, Community Care Licensing Division. Children may be placed in therapeutic foster homes, group homes, or residential treatment centers if the facility is licensed pursuant to Community Care Facilities Act and has an DSS established rate.

Specialized group homes and residential treatment centers are agency operated and provide for the longer-term comprehensive residential treatment of children and youth suffering from moderate to severe emotional problems or mental disorders and who cannot be maintained in their own home or community setting. In addition, some of these settings have as a primary goal the assessment, and not treatment, of the child and youth.

Group homes are more restrictive than foster homes since there may be a staffing pattern not reflective of a typical "family unit." They provide active programming and specialized support services according to a defined program model. Residential treatment centers are typically more structured and have a larger number of residents than the group homes. Both of these types of facilities are also regulated through DSS/CCL and qualify for a rate classification level within the DSS funding system. There may be additional treatment funds available through a Department of Mental Health Medi-Cal/Short-Doyle contract or Department of Developmental Services Medi-Cal if they are a client of a regional center.

## Community-Based Hospitals

Community-based hospitals include the following: private psychiatric hospitals and medical hospitals with psychiatric units, private community psychiatric hospitals with a County Department of Mental Health Medi-Cal/Short-Doyle contract, university psychiatric hospitals, and county hospitals with psychiatric units. Placement is made at a hospital generally accredited by the Joint Commission of Accreditation of Hospitals (JCAH) that is licensed by the Department of Health or Department of Mental Health.

Inpatient treatment is considered a medical service. If a parent has a low income, then Short-Doyle, through its sliding fee schedule, can provide a modified cost and payment plan. For this to be relevant, the child must be in a Short-Doyle funded inpatient program. The Chapter 26.5 funding mechanism is not an avenue for payment of inpatient care since the child is hospitalized for medical, not educational, reasons.

Private psychiatric hospitals and medical hospitals with a psychiatric unit serve children or adolescents whose problems are acute and involve medical or psychiatric evaluation or treatment for a brief period of time, often less than 30 days. Both types of hospitals without a County Department of Mental Health Medi-Cal/Short-Doyle contract, may be unable to accept Medi-Cal for payment or to serve families of limited means.

University psychiatric hospitals, operated by universities that have medical schools, also serve the same type of acute care and also accept insurance. University hospitals are generally more able to accept children or adolescents with more complex problems and, because at least some of their funding comes from university sources, are often able to maintain children or adolescents for periods longer than 30 days, which is frequently the limit for hospital mental health coverage under most health insurance policies.

County hospitals have a limited number of beds for children or adolescents. They are, however, funded from public monies and can accept children or adolescents whose families must depend on public funds. Children and adolescents accepted for admission are usually in an acute state of crisis and usually are a danger to themselves or others in order to be considered for admission due to limited resources.

All hospitals, whether public or private, have due process protections for minors placed into the hospital by their parents. All hospitals also have a Patient's Rights Advocate assigned to the hospital to deal with complaints and concerns of minors regarding their hospitalization.

Discharge planning can be an area of difficulty. An example is a case where a child is about to be released from a hospital to a local school district with county mental health services. Confidentiality limitations require that a current signed release of information be included prior to any exchange of educational information between the staff of these agencies. These restrictions are based on laws which regulate patient's rights, since the Welfare and Institutions Code, Section

5328, limits the disclosure of information and records for patients. This code mandates that children and youth who are recipients of mental health services, and/or their parents and guardians, may designate, in writing, persons to whom records and information may be disclosed.

Public or private hospital social services should begin discharge planning in concert with the family soon after admission. Whenever a public agency service (residential treatment, day treatment, outpatient, or special education, etc.), is identified as a potential discharge recommendation, the social worker from the hospital should notify the Director of Mental Health from the child's county of residence. The director or designee should contact special education and/or social services to begin conjoint assessment and discharge planning for the minor in question. Parental permission must be secured before the notification is made. This transition from a more to a lesser restrictive level of care depends on the student's readiness for functioning in the community as well as the availability of appropriate community placements matched to meet the student's need.

### State Hospitals and State Developmental Centers

State Hospitals and State Developmental Centers are often the only choice for children with extremely severe behavior or emotional disorders. Children and youth who are dually diagnosed, with both severe developmental and emotional/behavioral problems, are sometimes too difficult to treat in the community due to lack of appropriate resources and are treated at the State Developmental Centers. The State Hospitals and State Developmental Centers are the most restrictive and generally involve long-term stays. Given the tremendous need and diminishing funds for mental health services, there is a much more rapid turnover of patients and their lengths of stay may now be measured in months, compared to the past decade when children or adolescents might have been expected to remain for years at a time. Most patients are funded through public monies.

**Out-Of-Home Care Costs for SED Students**

| Fiscal Year | *Persons | Amount | **Average |
|---|---|---|---|
| FY 86-87 | 97 | $ 2,949,028 | $2,536 |
| FY 87-88 | 341 | 10,643,731 | 2,601 |
| FY 88-89 | 510 | 16,199,539 | 2,647 |
| FY 89-90 | 754 | 23,765,941 | 2,627 |
| FY 90-91*** | 940 | 31,050,000 | 2,578 |

*The approximate number of SED students placed pursuant to Ch. 26.5

**The average monthly cost per child for California Department of Social Services (DSS) funded line item for special education pupil board and care

*** Based on DSS projections

From California Department of Mental Health (1991)

***It is important that once a placement is made, the LEA and mental health agency continue to be involved to monitor progress and assist in returning the student to a less restrictive environment at the earliest opportunity.***

## Juvenile Justice System

Juvenile Justice services such as the California Youth Authority (CYA) serve youth who have been committed to the CYA by Juvenile Court for violating the law. Some of their older adolescents may have been committed to the CYA from the Adult Court.

The CYA has its specialized treatment programs, as well as agreements with Camarillo and Napa State Hospitals for bed space. Although these wards are in the State Hospital system, their costs are paid by the CYA. The CYA's specialized treatment programs for seriously disturbed youth is entirely funded by the California general fund as the organization hires its own psychiatric staff for that service. Although individual youths may have insurance coverage through Medi-Cal or their parent's insurance, no attempt is made to recoup expenses unless the child, as a ward of the court, requires care not available on-site, such as major surgery or dental care.

## Out-of-State Placements

Children with serious emotional disturbances often require resources and support services beyond the scope of educational programming that challenge the best of the state and community facilities described above. Although California offers a wide range of programs and services, with the increase in out-of-home placements, too often appropriate community placements are unavailable. Consequently, the child may be placed out-of-state far from the family unit. Some of these programs are very expensive.

The programs described above are among the most restrictive placements for children available. They should be used only in cases where local services are absent or not appropriate. In addition, it is important that once a placement is made, the LEA and mental health agency continue to be involved to monitor progress and assist in returning the student to a less restrictive environment at the earliest opportunity.

## SECTION 5

# PERSONNEL DEVELOPMENT

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# PERSONNEL DEVELOPMENT

## Background

There are serious problems with the current level of training for virtually all disciplines involved in the education and treatment of children with serious emotional disturbances. Many administrators wishing to develop high quality programs will find themselves constrained by a severe shortage of adequately trained personnel. The appropriate education of teachers and support personnel is critical to the development of strong programs.

The personnel development issues considered here relate to both preservice and inservice training needs of all personnel involved in planning or providing programs in California for students with serious emotional disturbances. Personnel development activities include the identification, planning, delivery, and evaluation of training programs and specific training activities. These programs or activities include comprehensive educational programs for teachers, program specialists, school psychologists, counselors, nurses, social workers, or other professionals; intensive workshops or conferences in specific areas; as well as brief updates or ongoing staff development efforts. Training is most frequently provided by institutions of higher education in the case of preservice programs and by service delivery agencies (e.g., mental health agencies, school districts, SELPAs) in the case of inservice training.

Currently there is no organized effort to coordinate appropriate personnel development activities for all staff delivering educational and treatment programs for students with serious emotional disturbances. While students with serious emotional disturbances may receive services from a variety of agencies within a community, it is unusual for the professionals in these agencies to participate in any common or coordinated personnel development program. Of perhaps even greater concern, personnel providing professional services to students with serious emotional disturbances often have little or no specific training regarding the provision of appropriate services for this population of students.

There is a great deal of evidence that not enough teachers are being trained to work with students with serious emotional disturbances. The U.S. Department of Education (1990) in its annual report to Congress reported that more than 15 percent of all teaching positions in the U.S. in classes for children with behavioral or emotional disorders remained vacant in the 1987-88 school year. In California, the problem is probably even more acute. There are currently five postsecondary programs in California that are providing specific training for individuals preparing

*Currently there is no organized effort to coordinate appropriate personnel development activities for all staff delivering educational and treatment programs for students with serious emotional disturbances.*

to teach children with serious emotional disturbances, compared to approximately 45 institutions that provide training in the other areas of special education.

There is also evidence to suggest that many professionals have been inadequately trained, if they have received any training at all, in the complexity of delivering services to students with serious emotional disturbances. A recent study (Grosenick, 1987) reported in 126 school districts studied across the U.S., 32 percent employed SED teachers who were not fully certified and almost 7 percent had no SED teachers who were fully certified. In California, the shortage of fully credentialed special education personnel is even greater than the national average. In a recent report to the Commission on Teacher Credentialing (Ad Hoc Committee on Special Education Personnel Availability, 1990), between 15 percent and 26 percent of all special education teachers serving handicapped students in California were found to be teaching on the basis of an emergency credential or a waiver of requirements.

Because of this lack of trained professionals available, school districts must seek waivers for inadequately trained teachers. Many teachers of students with serious emotional disturbances who do not hold special education credentials are hired as uncertified "permanent" substitute teachers by waiving the credential requirements. There is usually no requirement to obtain additional training while teaching in this position. Other teachers are hired on the basis of intern or emergency credentials and given full-time teaching responsibilities in SED classrooms while they are attempting to complete their training. While most teachers have received some training in academic instruction and classroom management of children with behavioral or emotional problems, they have probably received little or no training in the coordination of services needed by these children and their families. These conditions exist on both public and nonpublic campuses.

For the mental health profession, staffing shortages of qualified professionals serving students with serious emotional disturbances are also of critical proportions across the state, especially in rural settings and monolingual communities. Although the California Schools of Social Work have progressively expanded their programs both geographically and programmatically, offering part-time programs and incentives for paraprofessionals to seek advanced degrees, many new social workers do not enter the public sector.

There are additional shortages for all categories of "related services" personnel who provide essential support services for SED programs. School psychologists, social workers, counselors, and other diagnostic staff are all in tremendous need in California. The same problem is evident for mental health professionals serving children with serious emotional disturbances in mental health settings. As one example, the UCLA Department of Psychiatry is one of the largest child psychiatry training programs in the United States but it graduates only eight or nine child psychiatrists each year; approximately six choose to practice in California. Paul Wohlford, Director of Child Psychology Training Programs for the National Institute on Mental Health, has recently indicated that there is a serious shortage of mental health professionals in the U. S. and that the shortage is particularly acute in child services. (Magrab & Wohlford, 1990).

Social work and other professional staff shortages are exacerbated by the high turnover rate at mental health agencies. Turnover occurs when funding is unpredictable or inadequate. Retention of qualified staff becomes a key issue when considering the need for experienced staff in a clinical setting and also for providing training and technical experience for other key professionals in education and social services.

Mental health professionals must have the skills to implement programs, such as Chapter 26.5, which require knowledge of dual diagnoses, school related disorders, coordination of treatment, case management, and eligibility for special education. Professional training can set a framework for this knowledge base, but there is a need for additional training and positive on-the-job experiences to reinforce the training.

Improvements in preservice training for SED professionals will require significant changes at the state level and commitment from university training programs. Until very recently, California had no definitive training requirements or standards for teachers credentialed to work with students with serious emotional disturbances. Under the regulations that governed the original programs for educationally handicapped (EH) students, teachers were required to have "specialized training," but there was never a specification as to the content of that training. Consequently, teachers of EH students had training that varied from attendance at a single district workshop to a full credential or master's degree program in the area of EH. The guidelines recently approved by the Commission on Teacher Credentialing (see page 104) provide for a special authorization for teachers trained to work with students with serious emotional disturbances, but this training will be required of only *newly hired* teachers of students with serious emotional disturbances.

Specialized training programs are also needed for other professionals providing specialized services to SED populations. School psychologists, social workers, mental health professionals, psychologists, psychiatrists, and others are often expected to consult with educators and parents regarding educational programs for students with serious emotional disturbances. Many of these individuals enter this arena with very limited experience or training in providing this type of service and can provide only minimal assistance to the students and those concerned with helping the students. Paraprofessional staff and child care workers have direct ongoing contact with students with serious emotional disturbances and can greatly benefit from specialized training.

## Collaborative Consultation Training Needed

There are many situations in which it is necessary to provide consultation to professionals working with students with serious emotional disturbances. Specialized training in collaborative consultation is crucial for the effective provision of comprehensive, integrated services to students with serious emotional disturbances.

Consultation may be provided to the general class teacher prior to the initiation of a formal referral for special education services or after it has been determined that the student is eligible for special education services and is continuing to spend a portion of the day in the general classroom. Consultant services may also be required by other professionals working with the students with serious emotional disturbances while they are being served in a special education or mental health setting. These services may be provided by skilled consultants trained in collaborative consultation who regularly serve as special education teachers, resource specialists, program specialists, counselors, school or clinical psychologists, psychiatrists, or other mental health professionals.

The goal of the consultant is to assist the other professional(s) in developing the requisite skills required to work effectively with the "problem" student to try to resolve the problem in the current setting before using the more intensive treatments. These services may be coordinated through a student study or IEP team or a community agency, or the specialist may work independently with the professional directly serving the student with serious emotional disturbances. Lewis and Doorlag (1991) suggest the following points be considered when consultation services are provided:

1. The consultant's job is to assist in developing a plan for working with the "target" student. They are not there to dictate the educational or treatment program.
2. The student continues to be the responsibility of the consultee who is in charge of the student's educational or treatment program.

***Consultation may be provided to the general class teacher prior to the initiation of a formal referral for special education services or after it has been determined that the student is eligible for special education services and is continuing to spend a portion of the day in the general classroom. Consultant services may also be required by other professionals working with the students with serious emotional disturbances while they are being served in a special education or mental health setting.***

3. An agreement should be established as to the role of both parties. While it may not be necessary to have this in writing, it is important that both are aware of the expectations of the other person.

4. It is important that both parties are considered as co-equals. While they may have different training and experience backgrounds, the consultee is responsible for the quality of the program, aware of the needs of the students, and can describe the performance of the students. The specialist is there to assist the other professional and will need to adopt an appreciation of the characteristics of the student's program context and the particular needs of the student.

5. Both parties should try to keep the focus of their discussions on solutions to the problems. Statements should be as specific as possible and should not digress to topics regarding other problems or concerns unrelated to the needs of the specific students.

6. The consultee should provide specific information on the behaviors of the student and on the interventions that have been tried. Data on the number of times a behavior occurs or how long it persists, the performance of the student in problem academic or social areas, or the success of an intervention can assist the specialist in providing feedback. The specialist may ask questions regarding this information to clarify understanding of the problem.

7. The specialist may suggest that additional data be collected on the problem behavior. The specialist should attempt to facilitate the collection of this data. Some specialists may assist with the initial collection of data on students.

8. The specialist should help to develop more than one possible intervention for the problem behavior. They should not be expected to provide the "one magic solution." The consultee should also expect to be actively involved in providing suggestions and developing possible interventions.

9. The interventions should be implemented in the way they were collaboratively developed. If consultees are not comfortable with the intervention or are unclear on the specifics, they should ask for clarification or assistance. The specialist may be able to model the intervention or inform them of other professionals using similar techniques that they could observe.

10. A plan should be devised to evaluate the effectiveness of the intervention(s). This plan should specify the type of data needed to evaluate the intervention. It should also include the length of time the intervention should be attempted and the alternative interventions that should be attempted if the initial one fails. A date should be set for both parties to review the progress of the intervention and to consider next steps. If it later becomes necessary to refer the student for more specialized services, the information collected on the student and the interventions during this consultation process should be shared with the appropriate parties.

11. The person working with the consultant should consider this experience as an opportunity to gain new skills in working with students with serious emotional disturbances. Once these skills are mastered, they should help them to work with other students with similar problems.

12. It is important that the consultee provide feedback to the specialist. They should provide an objective evaluation of the specialist's work with them as this feedback will assist the specialist in improving the services they provide to others.

## Personnel Development Resources

The California Departments of Education and Mental Health, the Commission on Teacher Credentialing (CTC), the Comprehensive System of Personnel Development Advisory Committee, and colleges and universities throughout California all have extremely important roles to play in the development of adequate personnel resources to serve this population of students. Mental Health and Education can provide leadership, guidance, and expertise to local agencies to specify program guidelines, identify expertise, and develop the training needs of SED personnel as a priority. The CTC can be responsive to the educational needs of students with serious emotional disturbances by increasing awareness of the knowledge and skills required by teachers preparing to serve these students. Colleges and universities must be encouraged to develop training programs for SED personnel based on state-of-the-art knowledge in each of the related disciplines serving youngsters with serious emotional disturbances and their families, as well as specific training in the skills required to coordinate services across disciplines and agencies. Multidisciplinary and transdisciplinary training should be encouraged in preservice training programs.

The vast majority of the personnel development funds and the major responsibility for developing inservice training activities occurs at the local level. Each agency or consortium must develop a systematic means for assessing their training needs, identifying resources, and conducting ongoing staff development. The Title 5 Specialist Authorization for a teacher of students with serious emotional disturbances (see page 104) serves as an excellent starting point to identify areas of competence which must be developed for SED personnel. Each discipline will also develop somewhat different areas of expertise to augment the academic and behavioral emphasis of the school program.

Staff development programs should model the collaborative framework discussed throughout this document. This means that all training efforts should contain an interagency focus. Expertise in one part of the system can then be utilized for the benefit of others in the network. Special education personnel can conduct workshops for community mental health collaborators on special education eligibility guidelines, with mental health therapists instructing teachers about family dynamics. University faculty involved in preservice training of SED personnel should be tapped to assist in guiding, conducting, and participating in inservice workshops as regular participants in the system.

The interagency cooperation and collaboration that is discussed throughout this book will require new relationships for personnel within and between educational and social service systems. The human interactions that take place through staff development activities are a forum not only for the development of specific skills, but for the establishment of trust and mutual support between service providers, teachers, and administrators. A specific purpose of inservice training for SED personnel is to enhance the communication and overall functioning of all aspects of the system serving students with serious emotional disturbances and their families. Effective staff development must therefore be ongoing, interactive, and cooperative. By sharing knowledge, developing relationships based on trust, and improving communication throughout the system, collaborative inservice training can serve to greatly enhance the skills of practitioners, as well as to improve the functioning of the system.

***Effective staff development must therefore be ongoing, interactive, and cooperative. By sharing knowledge, developing relationships based on trust, and improving communication throughout the system, collaborative inservice training can serve to greatly enhance the skills of practitioners, as well as to improve the functioning of the system.***

## Part VIII of Title 5 — California Code of Regulations
## Section 80604.

Authorization for Special Class with Primary Disability:

**Seriously Emotionally Disturbed**

(a) Programs of direct instruction shall be designed for candidates to develop specific skills and knowledge in each of the following competency areas:

(1) Causes, characteristics, and definitions of students with serious emotional disturbances

(A) Historical development

(B) Characteristics relative to problems of environmental conflict, personal disturbance, and learning disorders

(C) Etiological and dynamic theories

(D) Diagnostic, educational, and medical models

(E) Developmental/emotional/educational ramifications of children born addicted to drugs

(2) Assessment and curriculum design in academic and social domains
   (A) Academic skills
   (B) Affective development
   (C) Social skills
   (D) Self-management and study skills
   (E) Vocational skills
   (F) Behavior and impulse control

(3) Repertoire of varied instructional strategies
   (A) Teacher directed/mediated
   (B) Student-initiated
   (C) Peer-supported
   (D) Vocational/community-supported
   (E) Group and individual

(4) Classroom and advanced behavior management
   (A) Classroom organization
   (B) Ecological intervention
   (C) Contingency management
   (D) Crisis Intervention

- (E) Ethical considerations
- (F) Selection of least intrusive interventions
- (G) Behavioral data collection, interpretation, and use
- (H) Individual and group techniques
- ( I ) Reintegration/mainstreaming approaches

(5) Consultation and coordination

- (A) Community resources, including mental health agencies, child protective services, regional centers, and probation departments
- (B) Parent/professional collaboration
- (C) Other professionals, including resource specialists and regular classroom professionals

(b) Field work shall consist of:

(1) Application of the knowledges and skills gained in subdivisions (a) (1) through (5) above.

(2) The assessment of the candidate for the authorization will take place in a public school setting, or private school of equal status.

(3) The fieldwork experience will involve the completion of a minimum of 100 clock hours of direct contact with disturbances.

(4) The supervision of the candidate for the authorization will be provided by at least one person who is appropriately certificated for the area of service.

# EPILOGUE

# NEXT STEPS

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# NEXT STEPS

## California's Challenge to Create Comprehensive, Community-Based Programs

The student with serious emotional disturbances challenges the expertise and resources of the local education agency in providing appropriate educational programs and services. It is this challenge that must spur each school to coordinate all of its resources to address the needs of these students. In a population where a significant percentage are being sent out of California for their treatment and education, local schools must ask themselves whether they are truly utilizing all available community and state resources to offer a full continuum of service and program options to students with serious emotional disturbances.

### Sharing the Responsibility

Special education can not — and should not have to — be the sole provider of services for these students. Services for students with emotional disturbances must be conceptualized within the framework for *all* children. The responsibility for providing these services must be shared by parents, all teachers, pupil support and administrative personnel, and special education. Through a collaborative effort of all school personnel with parent involvement, the impact of an emotional disturbance may be lessened, thus decreasing the need for more costly, specialized, and segregated services.

A partnership of school personnel with parents through student study teams (SSTs) or students at risk programs can produce creative means of identifying and intervening with children who demonstrate potential difficulties in social, emotional, and behavioral development before problems become so serious as to warrant removal from the regular class. In this way, the expertise of SED personnel can enhance schoolwide efforts to reduce the risk of school failure of all students while also developing effective interventions for students before they require intensive specialized services offered in programs for students with serious emotional disturbances.

The responsibility for providing a full array of services, especially for these students, extends beyond the local school to the entire community. Local mental health agencies, social service agencies, probation departments, community colleges and universities, together with the specialized more intensive services of nonpublic schools, should jointly focus their resources to provide a comprehensive and integrated service delivery system that is responsive to the needs of students with serious emotional disturbances and their families. In this manner, communities can genuinely offer "comprehensive schools" that meet the needs of all children.

***To provide the coordinated, comprehensive system of interagency services needed by students with serious emotional disturbances and their families requires a consistant and sufficient allocation of resources that are provided as early in a child's life as possible.***

## Resolving the Definition Dilemma

A focus of early identification and intervention, such as in the Primary Intervention Project, may avoid the need for unnecessary labeling of some students as SED. However, to provide equitable, individualized services to students with a specific disability, the federal definition must be clarified. Another problem is that each state agency maintains their own specific definitions which are often similar, but not identical. Due to this inconsistency of eligibility criteria for services, each agency administers its own assessments and evaluations. Precious government resources are wasted in multiple intakes and reporting requirements. The Department of Mental Health initiative to create a System of Care for Seriously Emotionally Disturbed Children and Youth has successfully crossed these barriers in five California counties and needs to expand across the state.

## Allocating Sufficient Resources

Currently, most of the state budget for health and mental health care is focused on providing adult services rather than on preventive and early intervention activities for children. Additionally, funding for special education and other categorical programs is based on what State Director of Special Education Patrick Campbell calls a "failure-driven system," in which a child has to fail one or two years before assistance is provided. To provide the coordinated, comprehensive system of interagency services needed by students with serious emotional disturbances and their families requires a consistant and sufficient allocation of resources that are provided as early in a child's life as possible.

Effective interagency coordination requires adequate resources. Secretary of Child Development and Education Maureen DiMarco observes, "If interagency coordination means doing more with less, as reform has come to mean, it won't work. We not only have to do a better job, but we have to have adequate resources to do the job." Successful models such as the System of Care model will require a specific allocation of funds, but the long-range cost savings have been well-documented. Refinement of outdated funding models such as that used for special education is also needed to refocus and expand current programs and services.

***Due to the uniqueness and complexity of emotional disturbances, students and their families need a variety of program and service options.***

## Providing a Full Continuum of Service Options

Due to the uniqueness and complexity of emotional disturbances, students and their families need a variety of program and service options. These include a protected setting for the most severe cases, to classes on regular schools, to designated instruction and services with general education placement. But the continuum must start at the local school in providing total services. The concept of the "community school" or the "comprehensive school" must be fully developed and address the special needs of students.

California communities must not continue to short-circuit the provision of services to students with serious emotional disturbances by placing these students far from their homes, and frequently out of state. Communities need to provide residential and specialized treatment settings for students with emotional disturbances. Levels of community tolerance will need to change in order to support these community-based programs. Local schools, both public and private, need to function as the "hub of services" for all their students, including those with serious emotional disturbances. This may include the collaboration of social services, welfare, mental health, probation, child care services, and even the recreation department. The options must be provided to each child and family in their own community.

This child-centered, family-focused perspective will necessitate a radical refocusing of bureaucratic state and local agencies. As Secretary DiMarco says, "We must focus on the child as the client, not the agency as the client."

## Empowering a Single Case Manager

To assist parents through the current bureaucratic maze of services, a single case manager must be empowered to access needed services. Effective case management can facilitate access to services in a consistent manner as families approach the various agencies and relocate to different communities. A single designated case carrier can efficiently coordinate services reducing unnecessary paperwork and delays and assisting in transitions from school to school, treatment setting to community, and school to work. In this way, parents can be relieved of having to fight for services or go without. All students with serious emotional disturbances have the right to have equal access to all needed services and should not be denied that right due to the absence of the parents, unavailability of local services, or intimidating, bureaucratic procedures.

***Without a child-centered focus, California's social services will be bankrupt by the year 2000.***

Within the current political climate in California, these steps can be accomplished. They will require a restructuring of current service delivery systems and funding models, but the '90s will be a time for massive reform (beyond education). They will also necessitate a refocus of service agencies to the child and family. Without a child-centered focus, California's social services will be bankrupt by the year 2000.

## Summary

This document was developed in a collaborative, multidisciplinary atmosphere to promote visibility of the current and emerging needs of this difficult student population. It has described the range and combinations of resources that already exist and addressed those that remain to be developed and/or expanded. Those successful and innovative models need to be promoted and replicated throughout California. Information and resources must continue to be provided to all individuals concerned with maximizing the potential of California's future — our children.

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# APPENDICES

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# DEFINITION OF SERIOUSLY EMOTIONALLY DISTURBED

## Federal Definition

**P.L. 94-142, 34 CFR 300.5 (b) (8) Federal Regulations**

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance.
(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(ii) The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

## State Definition

**California Code of Regulations, Title 5 Section 3030 (i) State Regulations**

(i) Because of a serious emotional disturbance, a pupil exhibits one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance:
(1) An inability to learn which cannot be explained by either intellectual, sensory, or health factors.
(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(3) Inappropriate types of behaviors or feelings under normal circumstances exhibited in several situations.
(4) A general pervasive mood of unhappiness or depression.
(5) A tendency to develop physical symptoms or fears associated with personal or school problems.

**Education Code, Section 56026**

"Individuals with exceptional needs" means those persons who satisfy all the following:
(a) Identified by an individualized education program team as a handicapped child as that term was defined in subsection (1) of Section 1401 of Title 20 of the United States Code as it read July 1, 1980.
(b) Their impairment, as described by subdivision (a), requires instruction, services or both which cannot be provided with modification of the regular school program.
(c) Come within one of the following age categories:
(1) Younger than three years of age and identified by the district, the special education local plan area, or the county office as requiring intensive special education and services, as defined by the State Board of education.
(2) Between the ages of three and five years, and identified by the district, the special eduction local plan area, or the county office as requiring intensive special education and services, as defined by the State Board of education; or between the ages of three and five years, inclusive, and identified by the district, special education local plan area, or county office pursuant to Section 56441.11.
(3) Between the ages of five years and 18 years, inclusive.
(4) Between the ages of 19 and 21, inclusive; enrolled in or eligible for a program under this part of other special education program prior to his or her 19th birthday; and has not yet completed his or her prescribed course

of study or who has not met proficiency standards prescribed pursuant to Sections 51215 and 51216. Any person who becomes 22 years of age while participating in a program under this part may continue his or her participation in the program for the remainder of the then current school year.

(d) Meet eligibility criteria set forth in regulations adopted by the board, including, but not limited to, those adopted pursuant to Article 2.5 (commencing with Section 56333) of Chapter 4.

(e) Unless handicapped within the meaning of subdivisions (a) to (d), inclusive, pupils whose education needs are due primarily to unfamiliararity with the English language; temporary physical disabilities; social maladjustment; or environmental, cultural, or economic factors are not individuals with exceptional needs.

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# TOPICS FOR INSERVICE

Staff development is a vital component in the organization and operation of an effective SED program. This is true from two standpoints. The first reason relates to issues regarding teacher recruitment and retention. An effective staff development program provides the necessary foundation for teachers who have little or no prior training or experience with this challenging population. It also provides the personal and programmatic support necessary for the retention of skilled professional staff.

The second reason for a comprehensive and on-going staff development program has to do with the intensive academic and behavioral needs presented by this population. Successful teaching in an SED program requires state-of-the-art understanding of core curriculum, learner characteristics and styles, pacing, instructional strategies as well as an in-depth understanding of the communicative function of behavior. The following is a sample of some components of a staff development program.

Behavioral Assessment
Burn-Out Prevention
Classroom Structure and Organization Specific to SED
Confidentiality
Cultural and Ethnic Components to Behavior
Data Collection
Effective Teaching Strategies
Interagency Collaboration Strategies
Nonaversive Behavior Interventions Strategies
Nonviolent Crisis Intervention
Personal Well-Being
Physical, and Sexual Abuse
Prevention and Management of Assaultive Behavior
Psychopharmacology
Psychological Testing
Self Esteem
Suicide Prevention/Response to Threats
Working with Families
Working With Paraprofessionals

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